STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER Arden Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy, and staff interviews for one (1) of three (3) residents (Resident #1) reviewed for allegations of neglect, the facility failed to notify the physician and resident representative of a change in condition and refusal of care. The findings include:Cross-reference F687 and F656.Resident #1?s diagnoses included mild cognitive impairment, dysthymic disorder (a continuous, long-term form of depression), left foot drop and moderate protein calorie malnutrition.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and was dependent on staff for personal hygiene, bed mobility and transfers.A Podiatry note dated 9/22/25 at 9:13 AM identified Resident #1's toenails were thick, yellow, brittle and contained subungual debris (crusty debris under the nail) with diagnoses of Peripheral Vascular Disease (PVD), neuropathy (nerve damage that causes pain and numbness), onychomycosis (fungal infection of the nail plate/bed) and dermatophytosis (fungal infection that thrives on keratin in the skin, hair and nails). The note identified that aseptic debridement (sterile removal of foreign debris, devitalized, necrotic or infected tissue to promote healing and prevent infection) was performed on all ten (10) of the elongated, thick toenails to viable (active/healthy) tissue and that Resident #1 would be followed up with in 6 to 8 weeks. Review of the clinical record from 9/22/25 to 2/9/26 failed to identify the provider or Resident #1's conservator had been notified of the condition of Resident #1's toenails following the 9/22/25 podiatry visit or the need for follow-up.The Podiatry Service Lists dated 11/10/25, 12/22/25 and 1/6/26 identified Resident #1 was due for follow up for tinea unguium (otherwise known as onychomycosis) but the visit was rescheduled and Resident #1 was not seen. The reason for the rescheduling was not identified.The Podiatry Service List dated 2/3/25 identified Resident #1 was due for follow up for tinea unguium but Resident #1 refused the visit.Nurse's notes dated 2/3/26 through 2/9/26 failed to identify documentation regarding Resident #1's refusal to see podiatry or that the provider or Resident #1's conservator had been notified of the refusal.The facility Reportable Event (RE) dated 2/9/26 identified they received a complaint alleging neglect due to the appearance of Resident #1's legs. The RE reported Resident #1 was seen by podiatry and wound personnel but refused treatments and Resident #1 had since been discharged .Interview with Person #1 (Resident #1's conservator) on 3/9/26 at 11:50 AM identified Resident #1 was transferred to another facility on 2/9/26 and he/she was present when a licensed nurse performed the admission assessment at the receiving facility. Person #1 identified Resident #1's toenails were so thick and long they started curling and reported he/she was shocked by the condition and appearance of the toenails. Person #1 identified the facility never notified him/her of podiatry issues or that Resident #1 refused treatment. Person #1 reported that had he/she known, he/she would have advocated for Resident #1, ensured Resident #1 received podiatry care and would have been present when the podiatrist visited to the facility.Interview with the DON on 3/9/26 at 12:37 PM identified although she was not employed by the facility in 9/2025, licensed nursing staff should have ensured after Resident #1 was seen by podiatry on 9/22/25 that they followed up with either the podiatrist or ensured the note was obtained (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and reviewed for procedures, orders and recommendations and that the provider and Resident #1's conservator were made aware of the condition of Resident #1's toenails. She identified Person #1 sent the facility pictures of Resident #1's legs and feet the same day Resident #1 was discharged on 2/9/26 and reported she (the DON) was unaware of the condition of Resident #1's toenails. She reported that her staff should have documented on the toenails and notified the unit manager or herself so they could have followed up with podiatry regarding Resident #1 and they should have notified both the provider and Resident #1's conservator when Resident #1 refused podiatry care on 2/3/26.Interview with APRN #1 on 3/9/26 at 1:22 PM identified she was never notified of the condition of Resident #1's toenails on 9/22/25 or that Resident #1 refused podiatry care on 2/3/26. She identified that nursing should have documented and notified her of the podiatrist's 9/22/25 visit and note indicating the condition of the toenails, as well as the continued growth and refusal of podiatry care. APRN #1 identified Resident #1 had multiple comorbidities and had she been notified of the 9/22/25 podiatry visit and associated note, she would have ensured Resident #1's feet and toenails were monitored and that podiatry followed up timely. She reported Resident #1 did not easily trust new faces and identified that if herself, other nursing staff, or Resident #1's conservator had been involved in the podiatry care, refusals of care may have been prevented. Review of the Notification of Change in Condition policy dated 6/1/21 directed, in part, the purpose of the policy is to provide appropriate and timely information about changes relevant to the resident's condition and the center must immediately inform the resident, consult with the resident's physician and notify the resident's healthcare decision maker when there is a need to alter treatment significantly or a change in the resident's physical status.Review of the Refusal of Treatment policy dated 3/1/22 directed, in part, if the resident is refusing treatment, staff will determine what the resident is refusing and why. Staff will try to address the residents' concern(s) and consult his/her supervisor. If the resident continues to refuse treatment, determine decision making capacity and inform the healthcare decision maker of the resident's refusal after discussion with the resident. Notify the physician of the refusal of treatment. Staff will determine and document what the resident is refusing, assess the reasons for refusal, advise the resident and healthcare decision maker of consequences of the refusal and offer alternative treatments.Review of the Foot Care policy dated 8/7/23 directed, in part, the purpose of the policy is to ensure residents receive proper treatment and care to maintain mobility and good foot health. The center will provide foot care and treatment in accordance with professional standards of practice and state scope of practice, including to prevent complications from the resident's medical condition(s) such as diabetes, peripheral vascular disease or immobility and ensure residents receive proper treatment and care to maintain mobility and good foot health. Residents who have complicating disease processes requiring foot care including, but not limited to, infections/fungus, ingrown nails, diabetes mellitus, neurological disorders, renal failure and peripheral vascular disease must be referred to qualified professionals such as podiatrists or other qualified providers.

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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 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 allegations of neglect, the facility failed to develop an individualized, comprehensive care plan to address the resident's left foot drop present on admission and podiatry abnormalities identified during admission. The findings include:Resident #1?s diagnoses included mild cognitive impairment, dysthymic disorder (a continuous, long-term form of depression), left foot drop and moderate protein calorie malnutrition.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and was dependent on staff for personal hygiene, bed mobility and transfers.The facility Reportable Event (RE) dated 2/9/26 identified they received a complaint alleging neglect due to the appearance of Resident #1's legs. The RE reported Resident #1 was seen by podiatry and wound personnel but refused treatments and Resident #1 had since been discharged .A. Hospital documentation dated 12/10/22 identified a past medical history with a diagnosis of left foot drop.Review of the Resident Care Plan (RCP) from 12/10/22 through 2/9/26 failed to identify that Resident #1 had left-foot drop or that interventions were initiated to treat the left foot drop.Interview with PT #1 on 3/9/26 at 12:15 PM identified Resident #1 was admitted to the facility in 2022 with significant left-foot drop. She reported that although therapy attempted to use Ankle Foot Orthoses (AFO) bracing on the left leg and foot, Resident #1 refused the AFO so it was discontinued. PT #1 identified the AFO and therapy were reattempted several times, but Resident #1 refused to participate or get out of bed. She reported that when Resident #1 was on therapy services, therapy would communicate all functional and Activities of Daily Living statuses and updates to nursing and nursing was responsible for developing the RCP with interventions. PT #1 identified Resident #1 should have had a comprehensive care plan to include left foot drop and the refusal of the AFO since admission to the facility on [DATE]. B. A Podiatry note dated 9/22/25 at 9:13 AM identified Resident #1's toenails were thick, yellow, brittle and contained subungual debris (crusty debris under the nail) with diagnoses of Peripheral Vascular Disease (PVD), neuropathy (nerve damage that causes pain and numbness), onychomycosis (fungal infection of the nail plate/bed) and dermatophytosis (fungal infection that thrives on keratin in the skin, hair and nails). The note identified that aseptic debridement (sterile removal of foreign debris, devitalized, necrotic or infected tissue to promote healing and prevent infection) was performed on all ten (10) of the elongated, thick toenails to viable (active/healthy) tissue and that Resident #1 would be followed up with in 6 to 8 weeks.Review of the Resident Care Plan (RCP) from 9/22/25 through 2/9/26 failed to identify Resident #1 had podiatry abnormalities including nail disorders, infections or foot and nail diagnoses to ensure proper treatment and prevent complications. Interview with the DON on 3/9/26 at 12:37 PM identified the interdisciplinary team (IDT) should have care planned Resident #1 for the left-foot drop that was present on admission, initiated interventions to prevent the foot drop from worsening and documented all treatments that were refused. She identified that licensed nursing staff who observed Resident #1's thick, long toenails or the IDT who first reviewed Resident #1's podiatry notes should have developed a podiatry care plan including interventions to ensure proper treatment to prevent complications.Review of the Person-Centered Care Plan policy dated 10/24/22 directed, in part, a comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual or significant change in status) and review and revise the care plan after each assessment. Care plans must describe the following: services that are to be furnished; any services that would otherwise be required but are not provided due to the patient's exercise of rights, including the right to refuse treatment and must include measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified in the comprehensive assessments. For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission. The care plan will be prepared by the interdisciplinary team.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for three (3) of three (3) sampled residents (Residents #1, #2 and #3) reviewed for allegations of neglect, the facility failed to ensure Resident Care Conferences (RCCs) were completed at least quarterly. The findings include:1. Resident #1?s diagnoses included mild cognitive impairment, dysthymic disorder (a continuous, long-term form of depression), left foot drop and moderate protein calorie malnutrition.A Care Plan Meeting note dated 5/5/25 at 12:42 PM identified that an RCC was held with Resident #1 and Resident #1's conservator.Review of the clinical record from 5/6/25 through 1/14/26 failed to identify that a subsequent RCC was scheduled or held for Resident #1.The quarterly MDS assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and was dependent on staff assistance for personal hygiene, bed mobility and transfers.Review of the clinical record from 1/15/26 through Resident #1's discharge date of 2/9/26 failed to identify that an RCC was scheduled or held for Resident #1 following the 1/15/26 MDS.2.Resident #2?s diagnoses included Alzheimer's disease with late onset (a brain condition that slowly damages your memory, thinking, learning and organizing skills), age-related macular degeneration (an eye disease that blurs one's central vision and leads to vision loss) and major depressive disorder.A Care Plan Meeting note dated 9/25/25 at 11:08 AM identified that an RCC was held with Resident #2's conservator.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4) and was dependent on staff for bed mobility and transfers.Review of the clinical record from 9/26/25 through 3/9/26 failed to identify that a subsequent RCC was scheduled or held following the 12/4/25 MDS.Although requested, an RCC signature sheet for Resident #2 was not obtained.3. Resident #3?s diagnoses included major depressive disorder, chronic kidney disease and generalized abdominal pain.The quarterly MDS assessment dated [DATE] identified Resident #3 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and was independent with bed mobility, transfers and ambulation.Review of the clinical record from Resident #3's admission date of 5/17/25 through 3/9/26 failed to identify that a 72-hour care plan meeting or RCC were scheduled or held.Although requested, an RCC signature sheet for Resident #3 was not obtained.Interview with the Director of Social Services on 3/9/26 at 1:46 PM identified the facility has had social service staffing challenges and 72-hour new admission RCC's, change in condition RCC's and quarterly RCC's had not been consistently completed. Interview with the DON on 3/9/26 at 12:37 PM identified RCC's should be completed within 72-hours of a resident's admission and then at least quarterly and further identified RCC's should have been completed timely for Residents #1, #2 and #3.Review of the Person-Centered Care Plan policy dated 10/24/22 directed, in part, that the center has the responsibility to assist residents to participate in care plan meetings by extending invitations to residents and resident representatives in advance and facilitating the inclusion of the resident and resident representative(s) to attend. Care Plan meetings will be documented by use of the Care Plan Meeting note.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and facility policy for one (1) of three (3) sampled residents (Resident #1) reviewed for allegations of neglect, the facility failed to ensure Resident #1 received ongoing podiatry care and timely follow-up after abnormalities were identified requiring follow-up within six (6) to eight (8) weeks. The findings include:Cross-reference F656. Resident #1?s diagnoses included mild cognitive impairment, dysthymic disorder (a continuous, long-term form of depression), left foot drop and moderate protein calorie malnutrition.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), and was dependent on staff for personal hygiene, bed mobility and transfers.A Podiatry note dated 9/22/25 at 9:13 AM identified Resident #1's toenails were thick, yellow, brittle and contained subungual debris (crusty debris under the nail) with diagnoses of Peripheral Vascular Disease (PVD), neuropathy (nerve damage that causes pain and numbness), onychomycosis (fungal infection of the nail plate/bed) and dermatophytosis (fungal infection that thrives on keratin in the skin, hair and nails). The note identified that aseptic debridement (sterile removal of foreign debris, devitalized, necrotic or infected tissue to promote healing and prevent infection) was performed on all ten (10) of the elongated, thick toenails to viable (active/healthy) tissue and that Resident #1 would be followed up with in 6 to 8 weeks.Review of the Resident Care Plan (RCP) from 9/22/25 through 2/9/26 failed to identify Resident #1 had podiatry abnormalities including nail disorders, infections or foot and nail diagnoses to ensure proper treatment and prevent complications.Review of the clinical record from 9/22/25 to 2/9/26 failed to identify further podiatry treatment for Resident #1 or refusal of podiatry treatment.Review of Nurse's notes from 9/22/25 through 2/9/26 failed to identify documentation regarding Resident #1's feet or toenails or refusal of podiatry treatment.The Treatment Administration Records (TARs) for September 2025 through February 2026 failed to identify treatments or monitoring were in place for Resident #1's feet or toenails.The Podiatry Service Lists dated 11/10/25, 12/22/25 and 1/6/26 identified Resident #1 was due for follow up for tinea unguium (otherwise known as onychomycosis) but the visit was rescheduled and Resident #1 was not seen. The reason for the rescheduling was not identified.The Podiatry Service List dated 2/3/25 identified Resident #1 was due for follow up for tinea unguium but Resident #1 refused the visit.Nurse's notes dated 2/3/26 through 2/9/26 failed to identify a note regarding Resident #1's refusal to see podiatry.The facility Reportable Event (RE) dated 2/9/26 identified they received a complaint alleging neglect due to the appearance of Resident #1's legs. The RE reported Resident #1 was seen by podiatry and wound personnel but refused treatments and Resident #1 had since been discharged .Interview with Person #1 (Resident #1's conservator) on 3/9/26 at 11:50 AM identified Resident #1 was transferred to another facility on 2/9/26 and he/she was present when a licensed nurse performed the admission assessment at the receiving facility. Person #1 identified Resident #1's toenails were so thick and long they started curling and reported he/she was shocked by the condition and appearance of the toenails. Person #1 identified the facility never notified him/her of podiatry issues or that Resident #1 refused treatment. Person #1 reported that had he/she known, he/she would have advocated for Resident #1, ensured Resident #1 received podiatry care and would have been present when the podiatrist visited to the facility.Interview with the Administrator on 3/9/26 at 12:35 PM identified she was unaware of the 9/22/25 podiatry note for Resident #1 and that podiatry notes are all sent to Medical Records and Medical Records staff communicates with the podiatry group by email. The Administrator identified licensed nursing staff should be aware if there are recommendations from podiatry but was unsure of how that occurred.Interview with the Director of Nursing (DON) on 3/9/26 at 12:37 PM identified licensed nursing staff should have followed up with the podiatrist and/or obtained and reviewed the podiatry visit note for orders and recommendations following the 9/22/25 visit. The DON stated she was (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unaware of the condition of Resident #1's toenails until 2/9/26, when Person #1 provided photographs of the resident's legs and feet after discharge. She indicated staff should have assessed and documented the condition of the toenails and notified the unit manager or DON to facilitate timely podiatry follow-up. The DON further identified there was no designated nursing staff responsible for coordinating or assisting with podiatry visits, and at the time of the 2/9/26 allegation, the facility did not have a process to ensure specialty providers communicated findings and recommendations to nursing staff prior to leaving the facility. Additionally, the DON reported that during her investigation, she misinterpreted the Podiatry Service Lists dated 11/10/25, 12/22/25, and 1/6/26 as refusals and was unable to determine why the resident was not seen by podiatry on those dates.Interview with APRN #1 on 3/9/26 at 1:22 PM identified she was never notified of the condition of Resident #1's toenails on 9/22/25 or that Resident #1 refused podiatry care on 2/3/26. She identified that nursing should have documented and notified her of the podiatrist's 9/22/25 visit and note indicating the condition of the toenails, as well as the continued growth and refusal of podiatry care. APRN #1 identified Resident #1 had multiple comorbidities and had she been notified of the 9/22/25 podiatry visit and associated note, she would have ensured Resident #1's feet and toenails were monitored and that podiatry followed up timely. She reported Resident #1 did not easily trust new faces and identified that if herself, other nursing staff, or Resident #1's conservator had been involved in the podiatry care, refusals of care may have been prevented.Although attempted, an interview with Person #2 (facility podiatry representative) was not obtained.Review of the Foot Care policy dated 8/7/23 directed, in part, the center will provide foot care and treatment in accordance with professional standards of practice and state scope of practice, including to prevent complications from the resident's medical condition(s) such as diabetes, peripheral vascular disease or immobility and ensure residents receive proper treatment and care to maintain mobility and good foot health. Residents who have complicating disease processes requiring foot care including, but not limited to, infections/fungus, ingrown nails, diabetes mellitus, neurological disorders, renal failure and peripheral vascular disease must be referred to qualified professionals such as podiatrists or other qualified providers.Review of the Consultant Agreements and Responsibilities policy dated 3/1/22 directed, in part, the outside resource will apprise the Administrator in writing of recommendations, plans for implementation and continuing assessment through dated and signed reports which will document the length of the visit. Consultant reports will be retained for follow-up action and evaluation of performance. The Administrator will provide evidence of review of the recommendations.