

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/27/2026
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #1), reviewed for wandering, the facility failed to ensure adequate supervision for a resident with a known wandering behaviors identified at risk for elopement to ensure the resident was not able to exit the facility without staff knowledge, and failed to ensure hourly rounds were conducted in accordance with facility policy. The facility was notified after the resident was observed in a neighboring town 5.3 miles from the facility, and video surveillance identified Resident #1 was out of the building for approximately two hours. The failures resulted in a finding of Immediate Jeopardy. The findings include: Resident #1 was admitted with diagnoses that included dementia, anxiety, and seizure disorder. An elopement assessment dated [DATE] identified a wander risk with a history of wandering that places the patient at significant risk of getting to a potentially dangerous place, e.g., stairs, outside facility. Record review identified Resident #1 had a court appointed Conservator and resided on a secured unit on the fourth (4th) floor. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 1 had severe cognitive impairment (Brief Interview for Mental Status BIMS of four), had no wandering behavior in the prior seven (7) days, and required supervision transfer and walking up to fifty (50) feet. The Resident Care Plan (RCP) dated 5/28/2026 identified Resident #1 was at risk for elopement, falls, was on anticoagulant therapy and had impaired thought processes. Interventions directed to keep the environment free of hazards maintaining a safe environment. Psychiatric APRN #1 note dated 7/15/2026 identified Resident #1 was seen for persistent agitation with wandering, and repeated attempts to leave the unit reporting he/she needed to get out. The note directed to increase Zyprexa (antipsychotic drug, used to treat behaviors in dementia) from 2.5 milligrams to 5 milligrams daily and to continue to monitor. Nursing note written by the DON dated 7/22/2026 at 11:57 AM identified Resident #1 was not on his/her assigned floor. Family called to notify staff that Resident #1 was seen outside facility on a street. Staff went to the location where Resident #1 was and observed. Resident #1 was assessed with no injuries identified. A facility reportable event (RE) dated 7/22/2026 at 11:50 AM identified Resident #1 was self-ambulatory, and the facility was notified Resident #1 was observed by family friend on local street. Additional review failed to identify a specific location. Facility written statement by NA #2, dated 7/22/2026, identified Resident #1 was last observed on 7/22/2026 about 9:30 AM in the dining room. Facility written statement by NA #3, dated 7/22/2026, identified Resident #1 was last observed after breakfast on 7/22/2026 about 9:15 or 9:30 AM in the hallway with his/her coat on. Facility written statement by NA #5, dated 7/22/2026, identified Resident #1 was last observed on 7/22/2026 about 9:30 AM wearing his/her coat walking down the hallway. Interview and review of facility video with the Administrator on 7/27/2026 at 10:40 AM identified Resident #1 was last seen (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	entering or exiting. Facility documentation review identified staff education was initiated on 7/22/2026 and included not providing exit door codes to any contractors, only staff are to have exit door codes, re-education of facility elopement policy, and door codes were changed. Audits were initiated on 7/22/2026, and a QAPI meeting was held on 7/22/2026. Based on review of facility documentation, past non-compliance was identified. The facility policy Elopement Prevention dated 3/2026 directed in part, NAs should complete hourly observation rounds on each resident at risk for elopement.		