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Form Approved OMB
No. 0938-0391

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	02/26/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on clinical record review, observation and interview for the only sample resident (Resident #449) reviewed for dignity, the facility failed to ensure a urinary collecting device was handled in a manner to maintain dignity. The findings include: Resident #449 's diagnoses included unspecified Obstructive and Reflux Uropathy, unspecified unpacified dementia, moderate, without behavioral disturbance, psychotic disturbance. Mood disturbance and anxiety and Urinary Tract infection (UTI). The admission Minimum Data Set assessment dated [DATE] identified moderately impaired cognition and the resident requires moderate assistance with toileting hygiene, lower and upper body dressing The care plan dated 2/20/2025 identified Resident #449 requires indwelling catheter due to obstructive uropathy. Interventions included providing privacy bags, leg bags when appropriate and providing privacy and comfort. A physician's order dated 2/8/2025 directed to perform indwelling catheter care as needed. Observation of Resident # 449 at 12:32 PM the survey in the hallway by the nursing station identified the resident with an indwelling catheter without a privacy bag Interview with RN#4 on 2/18/25 at 12:32 PM identified Resident # 449 should have on a privacy bag and could not explain why the resident did not have a privacy bag. After the surveyor's inquiry the Nurse Aide (NA) was instructed to place a privacy bag over the urinary collecting devices.

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on record review, interviews, and review of facility policy for 3 of 5 residents (Resident #63, #134, and #153) reviewed for Care Planning, the facility failed to include residents in updating care plans and provide advanced notification of changes to to the resident's care plans. The findings included: 1. Resident #63's diagnoses included End Stage Renal Disease, Dependence on Supplemental Oxygen, and an Acquired Absence of Right Leg Below the Knee. The Resident Care Plan (RCP) dated 10/26/21 identified Resident #63 was independently capable of pursuing his/her own activities. Interventions included informing the resident of facility happenings and checking in to inquire if he/she needed anything. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #63 was cognitively intact, required supervision with bathing, utilized a manual wheelchair for mobilization, and was independent with chair/bed-to-chair transfers. A review of social service progress notes for the time period of 6/1/22 through 2/20/25 identified Care Plan meetings were held for the dates 6/3/24 (Attendees: Social Services, Nursing, and Resident #63), and 1/15/25 (Attendees: Unit Manager, Social Services, and Resident #63). The progress notes failed to identify Resident #63 had been invited to an RCP Meeting around the dates the MDS Coordinator identified for RCP scheduling of 7/13/23, 10/9/23, 12/15/23, 3/11/24, and 9/9/24, or had been included in the updating of his/her care plan. An interview on 2/18/25 at 1:04 PM with Resident #63 identified he/she was informed about plans for his/her care after the fact. Resident #63 further identified he/she was invited to a RCP Meeting on 1/15/25 but he/she had not been invited to participate in a RCP Meeting during the three year time period prior to that meeting. 2. Resident #134's diagnoses included Peripheral Vascular Disease (PVD), hemiplegia and hemiparesis affecting the left side, and chronic pain syndrome. The RCP dated 7/15/21 identified Resident #134 had a Court-appointed Conservator. Interventions included involving the conservator in care planning and to involve the resident in his/her care planning discussions. A review of social service progress notes for the time period 6/1/22 through 2/20/25 identified Care Plan meetings were held for the dates of 9/29/22 (Attendees: Social Work, and Conservator), 12/8/22 (Attendees: Social Work, and Conservator), 3/16/23 (Attendees: Social Work, APRN, and Conservator), 6/15/23 (Attendees: Social Services, APRN, and Conservator), 8/31/23 (Attendees: Dietician, Social Services, APRN, and Conservator), and 10/23/24 (Attendees: Social Services, Nursing, the APRN, Dietician, and Conservator). The Social Service progress notes failed to identify Resident #134 had been provided notification of any of his/her Care Plan meetings or been included in the updating of his/her care plan. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #134 had intact cognition, was dependent with personal hygiene, dressing, and rolling left and right, and had been at the facility since March of 2021. An interview with Resident #134 on 2/18/25 at 1:04 PM identified she/he was invited to his/her RCP Meeting on 10/23/24 but he/she had not been invited to participate in a RCP Meeting during the three year time period prior to that meeting. 3. Resident #153's diagnoses included Fracture of the Left Femur, repeated falls, and Benign Prostatic Hyperplasia (BPH). The RCP dated 7/14/23 identified Resident #153 had a Court-appointed Conservator. Interventions included involving the Conservator in care planning and involving the resident in choices. The quarterly MDS assessment dated [DATE] identified Resident #153 was cognitively intact, was dependent with dressing, required set up with eating, and utilized a manual wheelchair. A review of the MDS Calendar for 8/1/23 through 2/20/25 identified the MDS Coordinator provided Social Services notification Resident #153 was due for a RCP Meeting on or around 10/26/23, 2/2/24, 4/29/24, 7/29/24, 10/17/24, and 1/16/25. A review of Social Service progress notes for the time period of 7/1/23 through 2/20/25 failed to identify any RCP meetings for Resident #153 were held or that he/she had been included in the updating of his/her care plan. An interview on 02/20/25 at 11:11 AM with the Director of Social Services identified both the MDS Coordinators and Social Services were responsible for ensuring RCPs were scheduled and residents were invited. He further identified that attempts to contact a representative or their responsible party regarding RCP Meeting dates are documented within a Social Service progress note. The Director of Social Services failed to identify a reason multiple RCPs were not held for Residents #63, #134, and #153 and why no notification was made to Residents #63, #134, and #153 about their RCP Meetings. An interview with the DNS on 2/20/25 at 01:38 PM identified RCPs should be held upon admission, quarterly, yearly, and upon resident request. The DNS further identified residents should be invited to their RCP, even if there is a conservatorship in place for a resident, and the minutes of those meetings should be documented within Social Service progress notes. The DNS failed to identify why there were no RCP minutes documented for Resident #63, #134, and #153 within Social Service progress notes for multiple dates identified for RCP meetings to be held or why residents had not been invited to RCP Meetings. An interview with the DNS on 2/24/25 at 9:58 AM identified she failed to locate any additional evidence /documentation that Residents #63, #134, and #153 were invited to or had a RCP meeting occur during the time period of 1/1/21 through 2/24/2025. Review of the Facility's Person-Centered Care Plan Policy identified residents have the right to participate in the development of their care plan and be informed in advance of changes to their care plan. The policy further identified care plan meetings will be documented in a Care Plan Meeting Note and invitations to residents will be extended in advance of the Care Plan Meeting.

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 51182 Based on review of the facility's Personal Funds Account, review of facility documentation, facility policy and interview, the facility failed to ensure necessary coverage through a Surety Bond for the Resident Trust Accounts. The findings include: On 2/26/25 at 10:35 AM, interview and review of the Resident Trust Account (RTA) balances with the Financial Counselor indicated that the RTA balance for the period of 1/1/25 through 1/31/25 ranged from $ 111,410.22 dollars to $127,323.20. Additionally, the RTA balance for the period of 6/1/24 through 6/30/24 indicated a balance ranging from $0. 00 to $188,943.55. The RTA balance for the period of 7/1/24 through 7/31/24 identified a balance ranging from $3,506.39 to $304,637.38 during that time. The RTA balance for the period of 8/1/24 to 8/31/24 identified a balance ranging from $108,945.31 to $121, 039.58 during that time. The RTA balance for the period of 9/1/24 through 9/30/24 identified a balance ranging from $100,666.54 to $126,223.64 during that time. The RTA balance for the period of 10/1/24 through 10/31/24 identified a balance ranging from $103,754.05 to $115,255.42 during that time. The RTA balance for the period of 11/1/24 through 11/30/24 identified a balance ranging from $109,560.51 to $123.370.77 during that time. Furthermore, the RTA balance for the period of 12/1/24 through 12/31/24 indicated a balance ranging from $114,755.85 to $124,220.07. Review of the facility's surety bond identified the Resident Trust Accounts were insured for $100,000 effective June 3, 2024, through June 3, 2025. An interview with the Administrator on 2/26/25 at 11:57 AM identified the facility does not regularly monitor if the Resident Trust Account $100,000 Surety bond coverage was adequate and indicated she/he was unaware that the Resident Trust Account regularly exceeds the $100,000 coverage limit. After surveyor's inquiry, the Administrator indicated she/he was going to reach out to the Regional Director of Operations to reach out to the Comptroller raise the Surety Bond amount to cover Resident Funds. Subsequent to surveyor inquiry, on 2/27/25 the facility retroactively increased the amount of their Surety bond to $250,000.00 effective 6/3/24. The $250,000.00 amount of the Surety bond was still not sufficient funds to cover the period of 7/1/24 through 7/31/24 which identified a balance ranging from $3,506.39 to $304,637.38. (continued on next page)

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the Surety Bond policy dated 3/21 identified a surety bond guarantees compensation for any loss of a resident's funds that the facility holds, accounts for, safeguards, and manages. Further, the policy stated all funds entrusted to the facility are covered by the surety bond.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46046 Based on observations of dining, review of facility policy and interview for 1 of 6 dining rooms, the facility failed to ensure staff provided a homelike dining experience for residents. The findings include: An observation of 2/18/2025 at 12:48 PM identified the dining room area had six tables; two residents seated at four tables, four residents sitting at one table and three residents at another table. There were also three residents (Residents #53, #71 and #157) in wheelchairs seated on the left of the dining room facing the residents seated and the dining tables, one other resident (Resident #96) was seated in a wheelchair without a table, facing residents seated at tables on the right side of the dining room area. At 12:50 PM the meal cart arrived to the unit and two nurse aides (NA) initiated serving the meal trays to resident rooms on the unit and two other nurse aides initiated serving the meal trays in the dining room. Residents seated at the dining room tables were served their meals on trays. An interview with NA #1 on 12/18/2025 at 1:00 PM identified she/he worked at the facility regularly, floating to other units as needed and further indicated meals are always served to the residents on meal trays. Continued observation of the meal service in the dining room on the secured unit found two residents (Resident # 135) seated at two different tables without food but the other resident seated at each table was eating. The residents seated in wheelchairs without tables and Resident #135 had not been served any food and were facing the residents who had been served food and were eating. An interview with the charge nurse LPN #1, in the dining room at the time identified she/he did not know why the residents did not have food and asked NA#1 seated at a table feeding a resident. NA #1 indicated she/he was providing assistance with feeding. RN #8 Independent Nurse Consultant was present at the time of the observations and interviews introduced him/herself and had no comment regarding the current dining experience. An interview with the Director of Nursing Services (DNS) and the Regional Clinical Director on 2/20/2025 at 2:20 PM identified since the new operators of the Change of Ownership who took over the facility a few months ago, many clinical areas were noted to be in need of improvement and it has taken time coordinate residents to come to the dining room rather than eating in their rooms. The DNS further indicated more work is needed to improve the residents' dining experience. The Regional Clinical Director further indicated in-servicing of staff had begun after surveyor's observation of dining on 2/18/2025, but did not provide the in-services. A request for the facility policy and procedure for resident dining on the nursing units but one was not provided.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on clinical record review, observations, facility documentation, facility policy and interviews for the only sampled resident (Resident #136) reviewed for Physical Restraints, the facility failed to ensure the resident was free from physical restraints. The findings include: Resident #136's diagnoses included Alzheimer disease, paranoid schizophrenia and hypertension. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident # 136 as severely impaired and requires maximal assistance with bed mobility, personal hygiene and partial assistance with toilet transfers. The MDS further indicated no restraints utilized. The care plan dated 12/6/2024 identified Resident #136 demonstrates poor body alignment requiring use of custom wheelchair. Interventions included to report for any signs or symptoms of pain, fatigue, discomfort, poor tolerance while in custom wheelchair and report as indicated. The physician's orders failed to reflect an order for Resident #136's pelvic positioning belt. The Occupational Therapy (OT) notes dated 1/17/2025 identified Resident #136 referral is due for his/ her custom wheelchair program to get a replacement wheelchair cushion, elevating leg rests and to allow for repairs to be made. Occupational Therapy notes had no mention/ recommendation for a pelvic positioning belt. Observation on 2/18/25 at 10:45AM identified Resident #136 scooting in hallway in his/her wheelchair, Resident #136 was also observed with a pelvic positioning belt on. An interview with RN #4 (unit manager) on 2/18/25 at 10: 46 AM indicated Resident #136 can take off the pelvic positioning belt him/ herself. RN#4 asked Resident # 136 to unbuckle his/her belt, however, Resident #136 was not able to do so. An interview with OT #1 on 2/20/25 at 10:00 AM identified the belt on the wheelchair was called a pelvic positioning belt. She identified in some cases residents might receive a custom wheelchair. OT#1 also indicated residents who are believed to have issues maintaining an upright position while in a wheelchair are assessed to see if the pelvic positioning belt is appropriate for them. Once determined, then the Residents Care Plan and physician's order would be updated to reflect recommendations. OT#1 identified Resident #136 was recently assessed in January 2025 and it was determined a Pelvic Positioning Belt was not appropriate for Resident #136. On 2/24/25 at 12:19 PM observation of Resident #136 identifed the resident with pelvic belt on in hallway heading to dining room. The facility Physical Restraints policy updated in June 2024 identified a physical resistant as physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the resident cannot remove easily and one that prevents the resident from freedom of movement or normal access to his/her body.

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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** 46046 Based on clinical record reviews, facility policy review and staff interviews for 4 of 6 residents (Residents # 123) reviewed for pressure ulcers and Resident # 136 who utilized a gait belt, and (Resident # 164) reviewed for hydration and (Resident #196) reviewed for discharge, the facility failed to ensure a residents care plans were revised to reflect the needs of each resident and for policy for 3 of 5 residents (Resident #63, #134, and #153) reviewed for Care Planning, the facility failed to provide advanced notice to residents of Care Plan Meetings, provide documentation that Care Plan Meetings were held, and ensure revisions to the care plan to reflected involvement of the resident. The findings included : 1. Resident #123's diagnoses included protein calorie malnutrition, peripheral vascular disease, left below the knee amputation and dementia. A Braden skin risk assessment was completed on 6/9/2024 upon readmission identified at moderate risk for skin break down (score of 13). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #123's cognitive status was moderately impaired, required maximum assistance of staff for rolling to the right and left side while in bed, noted dependent on staff for transferring in and out of bed to the wheelchair, at risk for developing a pressure ulcer/injury and noted no pressure ulcers at the time the assessment was completed. The care plan dated 1/6/2025 indicated in part, Resident #123 was at risk for skin breakdown Intervention included: to conduct weekly skin checks by a licensed nurse, preventative skin care including lotions, barrier creams as ordered. A nursing progress note dated 1/15/2025 at 1:34 PM indicated Resident #123 was observed to have a new dark purple, non blanchable area on the right ankle with surrounding redness, the physician was notified and a new orders were obtained. The physician's orders dated 1/15/2025 directed to offload the right leg with a pillow while in bed every shift, apply skin prep followed by a foam dressing daily and as needed to the right ankle Deep Tissue Injury (DTI) for 14 days and to have the wound physician evaluate the DTI during the next scheduled wound round. Resident #123's care plan indicated at risk for skin breakdown identified additional interventions on 1/15/2025 to offload the right leg with a heel boot or pillow while in bed every shift, and to apply skin prep followed by a foam dressing to the right ankle DTI as ordered. The wound physician's note dated 1/16/2025 indicated education was provided to facility staff regarding the need to provide pressure relief, general offloading and frequent repositioning. A physician's order dated 1/16/2025 directed to apply a heel Medix boot (pressure relieving boot) to the right ankle even when Resident #123 was out of bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Braden skin risk assessment was completed on 2/01/2025 identified Resident #123 to be at high risk for skin break down (score of 12). An observation on 2/18/2025 at 11:45 AM identified Resident #123 up in an adaptive wheelchair with the right foot donned with a sock, turned laterally, resting inside the right wheelchair foot box. An observation on 12/18/2025 at 12:48 PM identified Resident #123 noted seated in a wheelchair at a dining table with the right foot noted in the same position. An interview and record review on 2/24/2025 at 1:20 PM with LPN # 1 (skin integrity/wound nurse) identified the wound was identified on 1/15/2025, an investigation was conducted but did not indicate the cause factor of the unrelieved pressure which lead to the development of a deep tissue injury. Review of the clinical record with LPN #1 identified no evidence turning and repositioning was consistently performed on Resident #123 who required maximum assistance to turn in bed and was dependent for transfer to and from the wheelchair. Additionally, no interventions were identified in Resident #123's care plan to turn and reposition to prevent skin pressure. An interview and record review with the Director of Nursing Services (DNS) on 2/25/2025 at 10:16 AM indicated from 12/18/2024 through 1/15/2025 when the DTI was identified (29 days later), no documentation of offloading of the heels or turning and repositioning was found. The DNS indicated the facility policy did not provide detailed measures to be put in place for each risk score. However, preventative measures for Resident #123 with a skin risk score of 12 or 13 should have included turning and repositioning, preventative skin care, pressure relieving boots, weekly skin checks and treatments as ordered by the physician all should have been included in the care plan. 2. Resident #136's diagnoses included Alzheimer disease, paranoid schizophrenia and hypertension. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident # 136 as severely impaired and requires maximal assistance with bed mobility, personal hygiene and partial assistance with toilet transfers. The MDS further indicated no restraints utilized. The care plan dated 12/6/2024 identified Resident #136 demonstrates poor body alignment requiring use of custom wheelchair. Interventions included to report for any signs or symptoms of pain, fatigue, discomfort, poor tolerance while in custom wheelchair and report as indicated. The physician's orders failed to reflect an order for Resident #136's pelvic positioning belt. The Occupational Therapy (OT) notes dated 1/17/2025 identified Resident #136 referral is due for his/ her custom wheelchair program to get a replacement wheelchair cushion, elevating leg rests and to allow for repairs to be made. Occupational Therapy notes had no mention/ recommendation for a pelvic positioning belt. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An in-person interview with OT #1 on 2/20/25 at 10:00 AM identified the belt on the wheelchair is called a pelvic positioning belt. She reported in some cases residents might receive a custom wheelchair. OT#1 identified residents who are believed to have concerns maintaining an upright position while in a wheelchair are assessed to see if the pelvic positioning belt is appropriate for them. Once determined, then the Residents Care Plan and physician's order would be updated to reflect recommendations. OT#1 further identifed Resident #136 was most recently assessed in January 2025 and it was determined that a Pelvic Positioning Belt was not appropriate for Resident #136. Subsequent to inquiry, Resident #136 care plan was undated on 2/20/20/2025 to reflect Resident (#136) prefers to have seat belt remain attached to personal wheelchair despite not needing it. The resident does not require a belt at this time. Observation of Resident #136 on 2/24/25 at 12:19 PM identified the resident with a pelvic belt on in hallway heading to dining room. However, review of Resident # 136's care on 2/24/25 failed to reflect rationale for the utilization of the pelvic positioning belt. An in-person interview with RN #4 on 2/24/25 11:42 AM identified staff relays on physician's orders and care plan to let them know if a pelvic positioning belt is required. An in-person interview with OT#1 on 2/26/25 at 11:56 AM identified care plans should be updated right away once a recommendation is made. She further indicated she was unable to explain why the care plan was updated on 2/202/25. OT # also indicated nursing is responsible for updating care plan. [NAME] Care Center Person Centered Care Plan (revised on 10/24/22) indicated in part that the care plan is to promote positive communication between patient, patient representative and team to obtain input into the plan of care to ensure effective communication and optimize clinical output. 3. Resident #164's diagnoses include dysphagia, moderate protein calorie malnutrition and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #164 had moderate cognitive impairment required set up for eating had no swallowing disorders and was on a therapeutic, mechanically altered diet. A physician's order dated 2/17/2025 directed to infuse Dextrose-NaCL (Sodium chloride) solution intravenously (IV) at 70 cc per hour for two liters. A physician's order dated 2/18/2025 directed to provide a house supplement with meals for poor oral intake three times daily. A physician's order dated 2/20/2025 directed to infuse Dextrose-NaCL (Sodium chloride) solution intravenously (IV) at 65 cc per hour for two days. Interview and clinical record review on 2/25/2025 at 10:00 AM with the DNS and the Regional Clinical Director indicated the care plan for Resident #164 had not been updated to reflect the need for intravenous hydration therapy but should have been. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #196's diagnoses included dementia and cerebrovascular disease. The social service notes dated from 3/11/2024 through 3/19/2024 indicated reaching out to other long term care facilities for transfer of Resident #196. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated in part no active discharge plan was in process. The social service notes dated from 4/29/2025 through 4/30/2024 indicated social service was reaching out to other long term care facilities for transfer of Resident #196. The quarterly MDS assessment dated [DATE] indicated in part, no active discharge plan was in process. The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #196 was significantly cognitively impaired, the family was participating in the assessment and goal setting, and an active discharge plan was in place. A nurse's note dated 12/11/2024 at 2:39 PM indicated Resident #196 was transferred to a health care center. The discharge MDS assessment dated [DATE] indicated Resident #196 had a planned discharge without anticipation of returning to the facility. An interview and record review on 2/26/2025 at 12:20 PM with the Director of Social Services (Social Worker # 1) indicated although no discharge care plan was initiated for Resident #196 one should have been. The facility policy labeled Person-Centered Care Plan indicated in part the care plan should be customized to each resident's needs and preferences, be communicated to appropriate staff, be reviewed and revised by the Interdisciplinary Team after the completion of each assessment and as needed to reflect the response to changing needs and goals. 5. Resident #63's diagnoses included below the Knee amputation, Stage Chronic Kidney Disease, and dependence on renal dialysis. The Resident Care Plan (RCP) dated 10/26/21 identified Resident #63 was independently capable of pursuing his/her own activities. Interventions included informing the resident of facility happenings and checking in to inquire if he/she needed anything. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #63 was cognitively intact, required supervision with bathing, utilized a manual wheelchair for mobilization, and was independent with chair/bed-to-chair transfers A review of the MDS Calendar for 6/1/23 through 2/20/25 identified the MDS Coordinator provided Social Services notification that Resident #63 was due for a RCP Meeting on or around the dates of 7/13/23, 10/9/23, 12/15/23, 3/11/24, 6/6/24, 9/9/24, and 12/9/24. (continued on next page)

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 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Care Center	850 MIX Ave Hamden, CT 06514

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Resident #63's RCP Meeting Sign in Sheets identified the resident had been invited to and attended a care plan meeting on 6/3/24 and 1/15/25. The facility failed to provide RCP Meeting Sign in Sheets around the dates of 7/13/23, 10/9/23, 12/15/23, 3/11/24, and 9/9/24.

A review of social service progress notes for the time period of 6/1/22 through 2/20/25 identified RCP meetings were held for the dates 7/3/24 and 1/15/25. The social service progress notes failed to identify a care plan meeting was held around the dates of 7/13/23, 10/9/23, 12/15/23, 3/11/24, and 9/9/24 and that revisions to the RCP reflected involvement of Resident #63.

An interview on 2/18/25 at 01:04 PM with Resident #63 identified he/she is informed about plans for his/her care after the fact. Resident #63 further identified he/she was invited to a RCP Meeting on 1/15/25 but he/she had not been invited to a RCP Meeting during the three year time period prior to that meeting.

An interview with the DNS on 02/24/25 at 09:58 AM identified that she failed to locate any additional documentation that Residents #63, #134, and #153 were invited to or had a RCP meeting occur during the time period of 1/1/21 through 2/24/2025.

6. Resident #134's diagnoses included knee amputation, chronic pain syndrome, and moderate protein calorie malnutrition.

The RCP dated 7/15/21 identified Resident #134 had a Court-appointed Conservator. Interventions included involving the conservator in care planning and to involve the resident in his/her care planning discussions.

A review of the MDS Calendar for 6/1/22 through 2/20/25 identified the MDS Coordinator provided Social Services notification that Resident #134 was due for a RCP Meeting on or around 3/29/23, 6/1/23, 8/31/23, 11/27/23, 3/1/24, 5/24/24, 8/20/24, 11/19/24, and 1/24/25.

A review of social service progress notes for the time period of 6/1/22 through 2/20/25 identified RCP meetings were held for the dates of 9/29/22, 12/8/22, 3/16/23, 6/15/23, 8/31/23, and 10/23/24. The social service progress notes failed to identify a RCP meeting was held around the dates 11/27/23, 3/1/24, 5/24/24, 8/20/24, and 1/24/25 and that revisions to the RCP reflected involvement of the resident.

The Quarterly MDS assessment dated [DATE] identified Resident #134 had intact cognition, was dependent with personal hygiene, dressing, and rolling left and right, and had been at the facility since March of 2021.

An interview with Resident #134 on 02/19/25 at 11:15 AM identified he/she is not invited to RCP Meetings.

An interview on 2/20/25 at 11:11 AM with the Director of Social Services identified both the MDS Coordinators and Social Services were responsible for ensuring RCP's were scheduled. He further identified that attempts to contact a representative or their responsible party regarding RCP Meeting dates are documented within a Social Service progress note. The Director of Social Services failed to identify a reason multiple RCP's were not held for Residents #63, #134, and #153 and why no notification was made to Resident # 134 about his/her RCP Meetings.

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NAME OF PROVIDER OR SUPPLIER Arden Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MIX Ave Hamden, CT 06514	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Resident #153's diagnoses included fracture of the left femur, liver disease, and hypertension. The RCP dated 7/14/23 identified Resident #153 had a Court-appointed Conservator. Interventions included involving the Conservator in care planning and involving the resident in choices. The Quarterly MDS assessment dated [DATE] identified Resident #153 was cognitively intact, was dependent with dressing and moving from a sitting lying position, and utilized a manual wheelchair. RCP Meeting Sign in Sheets for Resident #153 identified he/she had been invited to but declined to attend a RCP meeting on 10/30/24. The facility failed to provide any additional RCP Meeting Sign in Sheets for the dates of July of 2023 through February of 2025. A review of the MDS Calendar for 7/1/23 through 2/20/25 identified the MDS Coordinator provided Social Services notification that Resident #153 was due for a RCP Meeting on or around 10/26/23, 2/2/24, 4/29/24, 7/29/24, 10/17/24, and 1/16/25. A review of social service progress notes for the time period of 7/1/23 through 2/20/25 failed to identify any RCP meetings for Resident #153 were held and that revisions to the RCP reflected involvement of the resident. An interview on 02/20/25 at 11:11 AM with the Director of Social Services identified both the MDS Coordinators and Social Services were responsible for ensuring RCP's were scheduled. He further identified that attempts to contact a representative or their responsible party regarding RCP Meeting dates are documented within a Social Service progress note. The Director of Social Services failed to identify a reason multiple RCP's were not held for Residents #63, #134, and #153 and why no notification was made to Residents #63, #134, and #153 about their RCP Meetings. A joint interview with MDS Coordinators #1 and #2 on 2/20/25 at 11:20 AM identified that the MDS Coordinators are responsible for creating and emailing a monthly calendar to Social Services as notification RCP's are due for Residents. Staff members the calendar is sent to include Social Services, Medical Providers, Nursing, Recreation, Therapy, Dietary, and the facility Secretary. An interview with the Director of Nursing Services (DNS) on 02/20/25 at 01:38 PM identified that RCP's should be held upon admission, quarterly, yearly, and upon resident request. The DNS further identified Residents should be invited to their RCP, even if there is a conservatorship in place for a resident, and the minutes of those meetings should be documented within Social Service progress notes. The DNS failed to identify why there were not RCP minutes documented for Resident #153 within Social Service progress notes for multiple dates identified for RCP meetings to be held. An interview with the DNS on 2/24/25 at 09:58 AM identified that she failed to locate any additional documentation that Resident #134 were invited to or had a RCP meeting occur during the time period of 1/1/21 through 2/24/2025. Review of the Facility's Person-Centered Care Plan Policy identified that residents have the right to participate in the development of their care plan and be informed in advance of changes to their care plan. The policy further identified care plan meetings will be documented in a Care Plan Meeting Note and invitations to residents will be extended in advance of the Care Plan Meeting. (continued on next page)

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	075228	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Care Center	850 MIX Ave Hamden, CT 06514

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49100 51182

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observations, review of the clinical record, facility policy, and interviews for 1 of 3 residents (Resident #153) reviewed for pain management, the facility failed to follow physician's orders for pain management. Resident #153's diagnoses included fracture of the left femur, liver disease, and hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #153 had moderate cognitive impairment, was dependent on staff for personal hygiene and dressing, required maximal assistance with rolling left and right in bed, and utilized a manual wheelchair. The Resident Care Plan (RCP) dated 2/12/25 identified Resident #153 was at risk for alterations in mobility related to a left hip fracture. Interventions included : monitoring for pain and stiffness, medicate as ordered, and report to physician as indicated. The RCP further identified Resident #153 was at risk for substance abuse related to a history of addiction. Interventions included observing for evidence of substance use and providing social service visits for support. An Advance Practice Registered Nurse (APRN) order dated 2/12/25 for Resident #153 directed that non-pharmacological interventions and effectiveness should be documented every shift in supplementary documentation. If the resident is having pain, follow the provider's direction which may include pain medication. a. An Advance Practice Registered Nurse (APRN) order dated 2/12/25 for Resident #153 directed non-pharmacological interventions are to be used before (PRN) pain medication. A record review of Resident #153's pain management identified he/she reported pain on 2/12/25 at 4:18 PM, 2/12/25 at 8:00 PM, 2/13/25 at 12:23 AM, 2/13/25 at 12:17 PM, 2/13/25 at 4:58 PM, 2/14/25 at 11:48 PM, 2/16/25 at 1:03 AM, 2/16/25 at 5:26 PM, 2/16/25 at 8:00 PM, 2/17/25 at 6:00 AM, 2/17/25 at 2:35 PM and 2/17/25 at 5:49 PM. No non-pharmacological interventions for Resident #153 were documented within the electronic health record or on paper for the dates 2/12/25 through 2/17/25. b. An Advance Practice Registered Nurse (APRN) order dated 2/12/25 and having an end date of 2/19/25 for Resident #153 directed the administration of 2 tablets of 325 milligrams (mg) of Acetaminophen to be given by mouth every 4 hours as needed for mild pain (defined to be a pain level of 1-3 on a 10 point pain scale). If more than 3 doses within a 48 hour time period were given, the physician should be notified. A record review of Resident #153's pain medication administration identified on 2/14/25 at 5:33 AM 5mg of Oxycodone was given for a pain level of 0. It was further identified on 2/16/25 at 5:26 PM 5mg of Oxycodone was given for a pain level of 2. No Acetaminophen was administered to Resident #153 on 2/14/25. Tylenol was administered on 2/16/25 at 4:00 PM for a pain level of 3. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. An Advance Practice Registered Nurse (APRN) order dated 2/17/25 and having an end date of 2/18/25 for Resident #153 directed 5 mg of Oxycodone HCL to be given every 4 hours as needed for left hip fracture. A Medical Doctor (MD) order dated 2/18/25 and having an end date of 3/4/25 for Resident #153 directed 5 mg of Oxycodone HCL to be given every 4 hours as needed for left hip fracture. A record review on pain for 2/18/25 at 1:01 PM 5mg of Oxycodone was given for a pain level of 8 at 2:41 PM 5mg of Oxycodone was given for a pain level of 7. The duration between the two Oxycodone administrations was 1 hour and 40 minutes. An interview with Registered Nurse (RN) #3 identified narcotic pain medications are usually ordered with parameters for administration. RN #3 further identified that over the counter medication is usually administered for pain management before a narcotic would be administered, and if a resident reported no pain then no pain medication should be given. RN #3 failed to identify why on 2/14/25 at 5:33 AM 5mg of Oxycodone was given to Resident #153 for a pain level of 0. An interview with Advanced Practice Registered Nurse (APRN) #1 on 02/25/25 at 10:49 AM identified her expectation is that the nurses try to reposition a resident before administering any pain medication to Resident #153 and pain medication should not be given if there was a reported pain level of 0. An interview with the Director of Nursing Services (DNS) on 2/25/25 at 03:28 PM identified the reason no non-pharmacological interventions for pain were documented in the Medication Administration Record (MAR) was that the Electronic Health Record (EHR) was missing the codes for documenting the non-pharmacological interventions for pain. She further identified it was her expectation that nurses document the interventions used within a progress note if the EHR did not allow a type of documentation. The DNS failed to identify any documentation of a non-pharmacological intervention for pain within a progress note for Resident #153. Review of the Facility's Pain Management policy identified (PRN) medications will have defined parameters for use and documented in the MAR. Patients receiving interventions for pain will have documentation of non-pharmacological interventions and its effectiveness, effectiveness of the PRN medication, and ineffectiveness of routine or PRN medications including notification to the physician/APR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, observations, facility policy and interviews for 1 of 6 (Resident #123) reviewed for Pressure Ulcer/Injury, the facility failed to prevent the re-occurrence of a pressure injury on a resident identified at risk for pressure ulcers and failed to consistently apply a pressure relieving boot while out of bed and failed to consistently turn and reposition the resident ordered and for 2 of 6 residents (Residents # 67 and # 143) at risk for pressure ulcer development, the facility failed to consistently conduct wound assessments according to facility practice and policy. The findings included: 1.Resident #123's diagnoses included protein calorie malnutrition, Peripheral Vascular Disease (PVD), left below the knee amputation and dementia. A Braden Skin Risk Assessment completed on 6/9/2024 upon readmission identified at moderate risk for skin break down (score of 13). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #123's cognitive status was moderately impaired, required maximum assistance of staff for rolling to the right and left side while in bed, noted dependent on staff for transferring in and out of bed to the wheelchair, at risk for developing a pressure ulcer/injury and noted no pressure ulcers at the time the assessment was completed. The care plan dated 1/6/2025 indicated at risk for skin breakdown. Intervention included: conducting weekly skin checks by a licensed nurse, preventative skin care including lotions, and barrier creams as ordered. A nursing progress note dated 1/15/2025 at 1:34 PM indicated Resident #123 was observed to have a new dark purple, non-blanchable area on the right ankle with surrounding redness, the physician was notified, and new orders were obtained. The physician's order dated 1/15/2025 directed to offload the right leg with a pillow while in bed every shift, apply skin prep followed by a foam dressing daily and as needed to the right ankle-Deep Tissue Injury (DTI) for 14 days and to have the wound physician evaluate the DTI during the next scheduled wound round. Resident #123's care plan indicated at risk for skin breakdown identified additional interventions on 1/15/2025 to offload the right leg with a heel boot or pillow while in bed every shift, and to apply skin prep followed by a foam dressing to the right ankle DTI as ordered. The wound physician's note dated 1/16/2025 indicated the right ankle wound was a Deep Tissue Pressure Injury with persistent non-blanchable deep red, maroon or purple discoloration measuring 0.9 Centimeter (CM) length x 0.6 CM width with no measurable depth, with an area of 0.54 CM with no drainage. The evaluation further indicated significant contributing factors included but were not limited to being diabetic and vascular complicating factors, impaired mobility, general muscle weakness and inevitable effects of aging. The note also indicated education was provided to the facility staff regarding pressure relief, general offloading and frequent repositioning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 1/16/2025 directed to apply a heel Medix boot (pressure relieving boot) to the right ankle even when Resident #123 was out of bed. A Braden skin risk evaluation dated 2/1/2025 noted a score of 12 which identified Resident #123 at high risk of developing skin breakdown (238 days or 7 months, 24 days after the prior Braden skin risk evaluation was previously completed and 18 days after the DTI was noted). A physician's order dated 2/7/2025 directed to obtain an occupational therapy evaluation and to treat with eight visits within 30 days for wheelchair management and therapeutic activities. An observation on 2/18/2025 at 11:45 AM identified Resident #123 seated in a wheelchair with the right foot donned with a sock, turned laterally, resting inside the right wheelchair foot box. At 12:48 PM Resident #123 was noted seated in the wheelchair at a dining table with the right foot noted in the same position. A physician order dated 2/22/2025 directed to take a picture of the right ankle resolved DTI, every Tuesday and complete the skin and wound evaluation. In interview and record review on 2/24/2025 at 1:20 PM with LPN # 1 (Skin Integrity /Wound Nurse) identified the wound was identified on 1/15/2025. An investigation was conducted but did not indicate the cause of the unrelieved pressure which led to the development of a deep tissue injury. Review of the clinical record with LPN #1 identified no evidence turning and repositioning was consistently performed on Resident #123 from January 1, 2025, through January 14, 2025, who required maximum assistance to turn in bed and who was dependent on staff for transfers to and from the wheelchair. Additionally, no interventions were identified in Resident #123's plan of care for turn and repositioning to prevent skin pressure. LPN #1 further indicated the wound physician had determined the DTI was healed during the last week visit but to continue the treatment. No documentation in the resident record was found regarding a visit by the wound physician or a visit note indicating the DTI was healed/resolved by the wound physician. An interview and record review with the Director of Nursing Services (DNS) on 2/25/2025 at 10:16 AM indicated from 12/18/2024 through 1/15/2025 when the DTI was identified (29 days later), no documentation of offloading of the heels or turning and repositioning was found in the clinical record. The DNS indicated the facility policy did not provide detailed measures to be put in place for each risk score. However, preventative measures for Resident #123 with a skin risk score of 12 or 13 should have included turning and repositioning, preventative skin care, pressure relieving boots, weekly skin checks and treatments as ordered by the physician all should have been included in the plan of care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DNS further indicated from 12/18/2024 until 1/15/2025 when the DTI was found (29 days later) there was no evidence / documentation of offloading of the heels and the pressure relieving boots were not ordered until 1/29/2025 (14 days after the DTI was found). Further clinical document review identified the skin risk assessments had not been conducted per the facility policy. One Braden assessment was conducted on readmission 6/9/2024 and 2/1/25 (238 days or 7 months, 24 days after the prior Braden skin risk evaluation was previously completed and 18 days after a new DTI was noted). The DNS indicated that the Braden skin risk assessments were manually added to the electronic UDA (user defined assessment) by the MDS/clinical reimbursement nurse for the nursing staff to complete and will need to be realigned to reflect the facility policy. The DNS indicated the facility policy does not indicate detailed measures to be put in place for each category of risk, but preventative measures for a Resident(#123) with a skin risk score of 12(Moderate) or 13(high) should have been frequent turning and repositioning, preventative skin care, the pressure relieving boots and treatment applied as ordered by the physician and weekly skin checks by the licensed nurses Observation on 2/25/2025 at 10:47 AM with RN #6, the facility nurse educator identified Resident # 123 in the dining room lounge area seated in a wheelchair, the right foot donned with a sock resting laterally inside the footrest box. RN #6 wheeled Resident #123 to his/her room for the right foot dressing change and a pressure relieving boot was observed lying on top of the bedside table. RN #6 indicated the pressure relieving boot was used only while in bed but after the surveyor inquired into the physician's she/he indicated the order also directed apply while out of bed. RN #6 indicated s/he would apply it after completing the treatment. RN #6 further indicated the charge nurse was responsible to apply the pressure relieving boot as it is on the treatment kardex to be signed off by the licensed nurse. Further observation identified during the treatment of the right ankle an area of discoloration existed, and RN #6 took a measurement picture of the area. After the treatment RN #6 applied the pressure relieving boot and wheeled Resident #123 back to the dining room. Interview with LPN #1 the regular charge nurse for the unit seated at the nurse's station upon exiting Resident #123's room after the treatment was completed indicated s/he ensured application of the pressure relieving boot while Resident #123 was in bed and did not realize it was to be on while out of bed. An interview with MD #2, the wound physician, on 2/25/2025 at 11:34 AM indicated s/he had last evaluated Resident #123's DTI on 2/14/2025 determining it was resolved and ordered protective dressings to be changed every 3 days. MD #2 further indicated if the wound re-occurred the DNS could add Resident #123 to the next wound round visit. MD #1 indicated having seen Resident #123's right foot position in the wheelchair foot- rest box when out of bed which can cause pressure on the ankle at the location of the DTI. MD #1 further indicated she/he educated the staff on offloading and the need to turn and reposition Resident #123. MD #1 indicated the DTI could have been prevented with turning and repositioning, offloading and other preventative measures in place and utilized, if the pressure causal factor is not relieved a wound will occur and if not relieved it will not heal. After surveyor inquiry a physician's order dated 2/25/2025 with no time directed staff to obtain a right lower leg ultrasound and ankle brachial index test to rule out peripheral vascular disease. On 2/26/2025 (12 days after the visit was conducted) at 8:00 AM subject to surveyor inquiry, the facility provided the wound physician visit report dated 2/14/2025 indicating the right ankle-deep tissue pressure injury was improving with measurements at 0 cm length, 0 cm width, no depth and received an outcome of resolved. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy labeled Skin Integrity and Wound Management indicated in part to conduct risk evaluations (Braden) on admission/readmission, weekly for a month, quarterly and with a change of condition. The policy further indicated to implement pressure injury prevention for identified, modifiable risks factors, determine the need for heel offloading and implement wound treatments. 2. Resident #67's diagnoses included type 2 diabetes mellitus with Diabetic Autonomic Polyneuropathy, Chronic Kidney Disease, and hypothyroidism. Resident # 67 was admitted on [DATE]. Braden Scale Assessments were completed on 12/16/24 and 12/17/24 indicated the resident was at risk of skin breakdown. However, no further Pressure Ulcer Risk Assessments were completed. The admission Minimum Data Set assessment dated [DATE] identified Resident #67 was moderately cognitively impaired and required set up assistance for eating and oral hygiene, and substantial assistance for toileting. A Wound Care Progress note on 2/21/25 identified the resident was at risk for increased risk of wound incidence and/or impaired wound healing due to vascular complicating factors of multi-variable etiologies, urinary and bowel incontinence, impaired cognition, generalized muscle weakness, decreased mobility, poor overall general health, and inevitable effects of aging. The Resident Care Plan dated 2/17/25 identified the resident was at risk for skin breakdown with actual skin breakdown. Interventions included observing skin for any signs and symptoms of skin breakdown and to evaluate for localized skin problems. A physician's order dated 2/22/25 direct to take a picture of the coccyx wound and left heel DTI weekly and to complete the wound and skin evaluation. In an interview with the DNS on 2/26/25 at 10:50 AM identified Braden Scale Assessments should be completed on admission and weekly for 4 weeks. In an interview with the Regional Director on 2/26/25 at 1:00 PM the MDS Coordinator should be scheduling the Braden Scale Assessments. The DNS also indicated this process has not been consistently done but will be completed moving forward. 3. Resident #143's diagnoses included Chronic Lymphocytic Leukemia, Congestive Heart Failure (CHF), and chronic kidney disease. Resident # 143 was admitted on [DATE]. Braden Scale Assessments were completed on 11/29/24, 11/30/24, 12/20/24, 12/23/24, 12/25/24, 1/8/25, 1/9/25, 1/22/25. 1/23/25, 2/1/25, 2/2/25, indicating the resident was at risk for developing pressure ulcers. The admission Minimum Data Set assessment dated [DATE] identified Resident #143 was cognitively intact and required maximum assistance for toileting, showering, and personal hygiene. A physician's order dated 12/6/24 directed to check skin every week. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Care Center	850 MIX Ave Hamden, CT 06514

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated 2/21/25 identified the resident had actual skin breakdown. Interventions included evaluation for any localized skin problems and observing skin for signs and symptoms of skin breakdown. In an interview with the DNS on 2/26/25 at 10:50 AM identified Braden Scale Assessments should be completed on admission and weekly for 4 weeks. In an interview with the Regional Director on 2/26/25 at 1:00 PM the MDS Coordinator should be scheduling the Braden Scale Assessments. The DNS also indicated this process has not been consistently done but will be completed moving forward. Review of the Skin Integrity and wound Management policy dated 2/1/23 currently in effect, direct in part, to complete risk evaluation upon admission/readmission and weekly for the first month, quarterly thereafter and with a change in condition. 48792

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49100 Based on observations and staff interview, the facility failed to ensure the oxygen room, the eye washing room that contain medical supplies and soiled linen room were locked appropriately to ensure residents on a secured unit had no access to prevent a potential accident The findings include: a. Observation on 2/18/2025 at 11:46 AM of the secured unit (A/B wing) identified the oxygen room, with 4 oxygen tanks, eye washing room with medical supplies (mask and gloves) and the soiled lining rooms with soiled lining were not locked. Despite the Eye washing room and the Soiled Linen room having coded locks on were not utilized. Observation on 2/18/2025 at 11:53 AM of staff entering Eye washing room and soiled linen room without the benefit utilizing codes. Observation on 2/18/2025 at 12: 15 PM identified residents wandering the hall and holding on the eye washing door to help propel themselves. Interview with DNS and the Regional Clinical Director on 2/18/2025 at 1:56 PM identified all the storage areas should be locked and not accessible to residents. The DNS further indicated the Maintenance Department is responsible for ensuring the above areas have functioning locks and indicated she/he would bring these concerns to their attention. After inquiry on 2/18/2025 at 2:45 PM The Regional Clinical Director identified the Maintenance Department has fixed the locks on the lock secure unit (A/B wing) and staff will be doing quality checks on other floors/ units.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48880

Based on clinical record review, review of facility documentation, review of policy and staff interviews for 1 of 6 residents (Resident #105) reviewed for nutrition, the facility failed to ensure a nutritional assessment included the resident's food preferences for a resident at risk for nutrition with a significant weight loss. The findings include:

Resident #105 was admitted on [DATE] with diagnoses that included diabetes mellitus and Adult Failure to Thrive (a syndrome in older adults characterized by progressive decline in physical and mental functioning).

A nutritional assessment dated [DATE] identified Resident # 105's meal preferences were obtained but the information did not indicate any specific resident preferences.

The quarterly MDS assessment dated [DATE] indicated Resident #105 as cognitively intact with adequate hearing and clear speech. The MDS assessment further indicated the resident required set-up or clean us assistance for eating and noted the resident had not experienced a significant weight loss during the look back period of the MDS.

A nutritional assessment dated [DATE] indicated dietary would initiate a selective menu for an expanded meal preferences base.

A review of Resident #105's weights identified the following:: on 10/07/2024 the residents weight was 138.7 Lbs, on 11/03/2024 the resident's weight was 123.8 Lbs (10.7% weight loss in one month).

A dietician's significant weight change note dated 11/11/2024 identified a significant weight loss had occurred and that the etiology of the weight loss was unclear. A twice-a-day dietary supplement was added as an intervention. However, there was no indication that Resident # 105's food preferences had been reevaluated or discussed with the resident when the significant weight loss had been identified.

A dietician's significant weight change note dated 12/06/2024 identified Resident #105 continued to trigger significant weight loss and the weight loss was likely related to poor appetite and varied by mouth intake (PO) with a PO intake between 25% and 75%. The frequency of the nutritional supplement was increased from twice a day to three times a day as an intervention. There was no indication that the resident's food preferences had been reevaluated or discussed with the resident when PO intake was identified to be variable.

A care plan revised on 12/6/2024 indicated Resident #105 had nutritional risk related to inability to care for themselves. Interventions included honoring food preferences within meal plan and to offer alternate food choices if less than 50% was consumed at mealtime.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A dietician's significant weight change note dated 1/16/2025 identified Resident #105 continued to trigger significant weight loss and the weight loss were likely related to a history of poor appetite and varied PO intake. The dietician's note further indicated the resident's was on Remeron (a medication used to stimulate appetite) had been increased by the provider on 12/11/2024. Fortified cereal for breakfast was initiated as an intervention. There was no indication that the resident's food preferences had been reevaluated or discussed with the resident. A dietician quarterly/significant weight change note dated 2/12/2025 indicated the dietician met with Resident #105 and the resident visually appeared thin. The note indicated Resident #105 had expressed she/he would not eat if they did not like the food and the resident had requested a peanut butter and jelly sandwich with breakfast, lunch and dinner. The dietician note indicated that the dietician met with the resident to discuss food preferences on 2/12/2024 (three months after the initial significant weight loss had been identified). On 2/18/2025 at 1:19 PM observation of Resident #105 during dining identified the resident had consumed all of her/his peanut butter and jelly sandwich and had not consumed the main meal. On 2/24/2025 at 12:38 PM during dining identified Resident #105 had consumed all of her/his peanut butter and jelly sandwich and all of the pasta. The resident indicated that she/he liked peanut butter sandwiches and pasta. On 2/24/2025 at 10:27 AM an interview with the Food Service Director identified the Food Service Director or Food Service Supervisors would talk to residents about their food preferences on admission and with menu changes. Although requested, the Food Service Director was unable to provide Resident #105's food preferences from admission. Additionally, a review of the facility's dietary manager software with the Food Service Director identified the only food preferences for Resident #105 were food preferences placed on 2/12/2025. On 2/24/2025 at 2:30 PM, an interview with the dietician indicated that the resident's body mass index (BMI) was 20.3 and that, in general, for the resident's age and weight, the resident's BMI should be 23 or higher; the goal for Resident #105 was a gradual weight gain. The dietician identified Resident #105's weight loss was related to no appetite and the resident did not always like the facility's food. The dietician further indicated for weight loss interventions, the facility takes a food-first approach where regular food is used to help a resident's nutritional status. The food-first approach included taking the residents' food preferences into account to optimize food intake. The dietician indicated that she thought that food preferences were taken on admission. Additionally, the dietician indicated she did not speak to the resident about their food preferences after the significant weight loss was identified on 11/11/2024 until she met with the resident on 2/12/2025 (three months after the initial significant weight loss had been identified). The facility policy for Nutrition/Hydration Care and Services last revised on 2/01/2023 identified on admission eating and drinking likes and dislikes are obtained. Additionally, the policy indicated the facility would develop an Interdisciplinary plan of care for enhancing oral intake, promoting adequate nutrition, and identifying individualized goals, preferences, and choices.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48792 Based on observations, facility policy review and staff interview for 4 of 8 medication rooms observed (Unit 2A/B and 3 C/D), the facility failed to ensure stock medications were not expired. The findings include: Observation of medication stock rooms located on Unit 2A/B on 2/26/25 at 10:39 AM with RN#6 identified the following expired medications; 1 bottle of Aspirin 325 mg expired 8/24, Carbamide Peroxide ear drops 65% expired 12/24, and 3 Heparin Flush IV syringes expired 11/24. Observation of medication stock rooms located on Unit 3 C/D on 2/26/25 at 10:50 AM with RN #6 identified a bottle of Aspirin 325 mg expired 8/24. In with the Regional Director of Nursing and the Director of Nursing Services on 2/26/25 at 11:00 AM identified the process to ensuring that all medications are not expired consists of the Central Supply Office staff member who stocks the medication rooms look at the expiration dates of the stock. Central Supply Office staff member will move the newest medications to the back and bring the oldest medications to the front to ensure they are used first. However, there is no set process or frequency to review stock medications. In addition, the nurses should be checking the dates of the stock medications before placing them on their medication carts. Review of the Medication Storage Policy, undated and currently in effect, directs in part, expired, discontinued, and/or contaminated medications will be removed from the storage areas and disposed of in accordance with facility policy.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on review of the clinical record, facility policy and interviews for 1 of 1 resident, (Resident #134) reviewed for dental, the facility failed to identify and provide emergency dental services for a resident who dentures were lost. The findings include: Resident #134's diagnoses included vascular dementia, left sided hemiplegia and hemiparesis, and chronic pain syndrome. The Resident Care Plan dated 9/1/23 identified Resident #134 exhibited or was at risk for oral health care. Interventions included monitoring for mouth pain and providing oral hygiene/mouth care twice per day and as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #134 had no cognitive impairment, required clean-up assistance with eating, was at risk for malnutrition, and was dependent with rolling left and right. A provider note dated 12/18/24 identified Resident #134 had no oral or mouth pain and was eating food provided to her/him by the facility. The note further identified the resident had a recent weight gain. The facility Dental Group Schedule dated 1/2/25 identified Resident #132 was scheduled to see Dental Services on 1/2/25 within the facility in the Occupational Therapy room. A dental note dated 1/2/25 identified Resident #134 had lost his/her dentures. The note further identified the facility was notified of the missing dentures and staff was instructed to look for them. The quarterly MDS assessment dated [DATE] further identified Resident #134 was dependent with oral hygiene and had no broken or loosely fitting dentures or mouth pain. An interview with Resident #134 on 02/19/25 at 11:16 AM identified he/she had lost his/her dentures, informed staff they were missing, and the dentures had not been located. A review of the facility's grievance log for years 2024 and 2025 on 2/25/25 at 11:15 AM failed to identify and documentation Resident #134's dentures were missing. An interview with Registered Nurse (RN) #3 on 2/25/25 at 11:41 AM identified nursing was responsible for reviewing completed dental notes, entering missing dentures into the grievance log, and notifying the nurse manager of the missing item. An interview with RN #5 on 2/25/25 at 11:54 AM identified she was not made aware by nursing Resident #134's dentures were missing. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing Services (DNS) on 2/25/25 at 12:24 PM identified the Assistant Director of Nursing Services (ADNS) was responsible for reviewing specialty provider notes after resident appointment. However, there was no ADNS currently employed by the facility. Until a new ADNS was hired, the nurse managers were responsible for reviewing the specialty provider notes after a resident was seen. The nurse managers were directed to review the Dental Group Schedule every day and review the notes for residents seen on that day. The DNS further identified a resident who loses their dentures should receive a Speech Consultation for a dietary consistency downgrade, have an entry for their missing dentures placed in the grievance log, and receive an appointment with the dentist for new dentures if the dentures cannot be found. Review of the Facility's Oral Health Policy failed to address the care and maintenance of dentures. Review of the Facility's Personal Property policy identified any loss of a resident's personal item will be documented on a property loss form and an investigation by the administrator or designee will occur.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46046 Based on observations of the kitchen, review of facility documentation, review of policy and staff interviews, the facility failed to ensure the kitchen was clean and sanitary and kitchen equipment was operating properly. The facility also failed to consistently monitor temperature logs and ensure food items were dated and labeled. The findings included: 1 . a. An observation and interview with the Dietary Manager on 2/18/2025 starting at 10:15 AM and ending at 11:15 AM identified water and food debris on the floor under the prep sink area that had two open drains directly draining dirty water onto the kitchen floor near a floor drain. The Dietary Manger identified the sink drain strainer help to keep the food debris from going down the drain was missing and needed to be replaced which caused the drains to empty directly onto the floor and the fluid is expected to reach and go down the floor drain. The Dietary Manager pointed out some tiles on the floor in the prep sink area that were missing from the repeated water buildup. S/he further indicated the facility has no basement and the kitchen floor would require excavation and plumbing to be laid to correct the drainage. This had previously been done in the other part of the kitchen to correct drainage issues. b. The Kitchen Manager provided a demonstration of the coffee maker/serving appliance overflow grate, the fluid drained directly onto the floor then flowed several feet to another floor drain located within a frequently walked area by the staff of the kitchen. The Dietary Manager also indicated they try not to get any fluid into the overflow grate to prevent the flow of water onto the floor. 2. Observation of the walk-in refrigerator thermometer inside identified the device was broken but another thermometer was found in another area of the walk-in. The Dietary Manager indicated having many spare thermometers to replace the broken ones as it occurs often. Observation of a stand-alone refrigerator freezer located near the stove had a broken thermometer inside and no thermometer inside the freezer which contained a solid, clear bag, of frozen vegetables. However, the stand-alone refrigerator/freezer had one temperature list for the month of February 2025 which the Dietary Manager indicated contained refrigerator temperatures that was labeled Freezer temperatures. No temperature log or documented temperatures from 2/1/ 25 through 2/18/25 (17 days) for the freezer were located. The Dietary Manger indicated the wrong temperature log was posted and no freezer temperatures had been taken or logged. After the surveyor inquiry, the Dietary Manager indicated she/he would immediately post the correct temperature logs and place a new thermometer in the freestanding refrigerator and a thermometer in the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 2/22/2025 starting at 11:30 AM observation of the kitchen staff conducting meal plating and tray line was done. The Dietary Manager and surveyor followed the last meal cart to the 3rd floor at 12:50 PM. At 12:53 PM. Observation and interview with the Dietary Manager of the refrigerator inside the locked kitchenette on the C-D unit found many food items from outside sources/resident food items either not labeled, labeled with only the resident name and room number and no dates. The Dietary Manager indicated the dietary department was responsible for what they place inside each kitchenette refrigerator and at this time it would be one sandwich which was labeled appropriately and indicated items are good for 3 days. An observation and interview with the charge nurse, LPN #7 indicated visitors and residents should be alerting staff if food items are brought into the facility. However, LPN# 7 indicated she/he was not sure who was responsible for labeling and dating the items. An interview and facility policy review with the Director of Nursing Services (DNS) on 2/22/2025 at 1:50 PM indicated the dietary department was responsible for ensuring that all food items were appropriately dated including food brought in from outside the facility. She/he also indicated the process would need to be reviewed. The facility policy labeled Food Storage indicated, in part, every refrigerator must be equipped with an internal thermometer and the refrigerators and freezers temperatures should be checked at least twice daily and frozen foods checked for firmness to ensure items are frozen solid. The facility policy labeled Food Brought in from Outside Sources and Personal Food Storage indicated in part, foods and beverages brought in from outside sources requiring refrigeration or freezing would be labeled with the resident's name, the date, and stored in the refrigerator/freezer apart from facility food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48880 Based on observations of the linen storage area and staff interviews, the facility failed to ensure clean linens were stored appropriately. The findings include: On 2/25/2025 at 11:30 AM during a tour of the laundry with the Infection Control Nurse (ICN) identified food items in a room containing clean linen for the 11:00 PM to 7:00 AM shift. The linen was stored in open, partially filled linen carts. The food items included an empty can of orange soda, an empty bag of crackers, aluminum foil with yellow residue on it, a can of cashews with cashew crumbs inside, an open single-serve packet of mayonnaise that still contained mayonnaise, an open piece of a red candy cane, two plastic forks with residue, two packets of unopened tea bags, one unopened cough drop, one unopened packet of sugar. The top shelf had two clean incontinence pads and several clean folded towels. On the bottom section of the shelf, there were two clean curtains and a folded, clean fitted sheet. The ICN identified the food items, the medication bottle, and the nail polish should not have been stored there. An observation and interview with the Director of Laundry/Housekeeping on 2/25/2024 at 11:35 AM indicated the food items should not have been stored there, and he did not know who the items belonged to. The Director of Laundry/Housekeeping indicated that the room was used to store linen for the 11:00 PM to 7:00 AM shift. The facility policy for linen handling did not indicate whether open food items were allowed in the linen room. However, the facility employee handbook indicated the facility-provided employee lounges and breaks may not be taken in work areas, and food and drinks may only be consumed in designated areas.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on clinical record reviews, review of the facility Immunization Program and staff interviews for 2 of 4 residents (Residents #110 and # 164) reviewed for vaccination, the facility failed to ensure residents received annual education on influenza vaccines and obtain annual informed consent. The findings include: 1. Resident #110 was admitted on [DATE] with diagnoses that included Alzheimer's disease and heart failure. The quarterly MDS assessment dated [DATE] identified Resident #110 had severe cognitive impairment. A record review and interview with the Infection Control Nurse (ICN) on 2/25/2025 at 11:00 AM failed to identify the administration of an influenza vaccine for the 2024-2025 season and failed to identify a written consent or refusal for the administration of the 2024-2025 influenza vaccine. The ICN was unable to indicate a reason why Resident #110 had not received an influenza vaccine for the 2024-2025 season. 2. Resident #164 was admitted on [DATE] with diagnoses that included dementia and cognitive communication deficit. A review of the facility admission record face sheet indicated Resident #164 had a Conservator of Person (COP) who was the responsible party. The quarterly MDS assessment dated [DATE] identified Resident #164 was moderately cognitively impaired. An influenza immunization informed consent form dated 10/31/2022 indicated Resident #164's COP gave verbal consent for annual influenza vaccination. A review of Resident #164's immunization record identified on 11/01/2022, the resident received an influenza vaccination, and the resident's COP was given a Vaccination Information Sheet (VIS). The immunization record further indicated on 10/20/2023, the resident received an influenza vaccine and was given a VIS. On 10/22/2024, the resident was given an influenza vaccine, but there was no indication the resident or the resident's COP was provided education on the benefits and potential side effects of the influenza vaccine. A nursing note dated 10/22/2024 indicated Resident #164 received an influenza vaccine but did not indicate if the resident or the resident's COP was provided education on the benefits and potential side effects of the influenza vaccine. On 2/25/2025 at 11:00 AM an interview with the ICN indicated that if a resident is self responsible the facility would talk with the resident individually, and if the resident is conserved, the facility would contact the COP or responsible party and obtain a signed consent. The ICN indicated that once the consent for annual vaccination is signed the same consent is valid for future influenza vaccinations. A review of the facility policy for Influenza Immunization indicated the facility would send a Vaccination Information Sheet (VIS) and a letter indicating if a consent was needed or already obtained to the resident or resident representative.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observation, review of facility documentation, review of policy and interviews for 1 of 7 residents (Resident #102) reviewed for Environment, the facility failed to ensure a three-foot clearance was maintained around a resident's bed. The findings include: Resident #102's diagnosis includes Type 2 diabetes mellitus. The quarterly MDS assessment dated [DATE] indicated in part Resident #102 was moderately cognitively impaired and independent for bed mobility and transfer. An observation on 2/18/25 at 11:33 AM identified Resident #102 asleep in bed. The left side and foot of the bed was noted up against the wall. An observation and interview on 2/25/25 at 1:48 PM with the Administrator identified Resident #102 in bed and asleep with a side of the bed against wall . The resident's foot of the bed close to the wall. After exiting the room, the Administrator indicated she/he had possession of some letters requesting waivers dated 2019 from the previous owner and would locate them for view. A discussion regarding the need for three-foot clearance surrounding the sides and foot of the bed and the potential of a bed against the wall might pose a restraint to a resident. An interview and facility document review on 2/25/25 at 02:35 PM with the Administrator provided a therapy evaluation and the Minimum Data Set to show Resident #102 was independent with bed mobility and transfer. The Administrator also indicated Resident #106 stated to the administrator s/he liked the bed where it was. The Administrator provided a review of the facility documents from 2019 indicating a room similar in size to Resident #102's and a letter to the state agency to request a waiver. She/he also explained one of the beds in the room would need to be against the wall to allow enough room for a resident in a wheelchair to access the bathroom. The Administrator indicated the facility presently had no waivers for three-foot clearance for the two-bed rooms of this size and she/he had plans to convert these smaller rooms to single rooms but since that will take time he/she would apply for a waiver. The Administrator indicated s/he had conducted a room audit, and no other residents' beds were against the wall. A copy of the audit was requested but not provided. Although a facility policy regarding bed clearance was requested the facility did not have a policy.