STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at St. Camillus	494 Elm St Stamford, CT 06902

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, review of facility policy and staff interviews for 1 of 4 residents (Resident #6) reviewed for abuse, the facility failed to keep the resident safe from physical and verbal abuse. The findings include:Resident #6 a conserved resident was admitted with diagnoses of bipolar disorder and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had moderately impaired cognition and exhibited verbal behaviors directed towards others. Resident #6 required substantial/maximal assistance for toileting, was independent in standing from a sitting position, and used a wheelchair for mobility. The MDS assessment further identified Resident #6 did not have any skin problems or wounds.The Resident Care Plan (RCP) dated 1/21/2025 identified Resident #6 was at risk for alteration in mood and behaviors as evidenced by yelling at staff. Interventions included leaving the resident alone and returning later if the resident was being abusive towards staff.A psychiatric evaluation dated 1/21/2025 identified Resident #6 exhibited baseline confusion, delusional thinking, and disorganized thought process with a tendency toward impulsiveness when irritable. Recommendations included close monitoring and behavioral documentation.A weekly skin observation tool dated 1/25/2025 identified no skin issues.A nursing note dated 1/29/2025 identified Resident #6 refused care and refused staff to enter her/his room, even to care for her/his roommate.A nursing note dated 1/31/2025 identified an ongoing investigation of abuse, and a full body audit was performed. The note identified an abrasion to the left arm measuring 4.0 Centimeters (CM) by 2.0 CM, and an abrasion to the right leg measuring 7.0 CM by 0.5 CM. The Advanced Practice Registered Nurse (APRN) was informed and reviewed, no treatment orders, leave abrasion open to air. Additionally, noted Resident # 6 was referred to psychiatry for a telehealth consult which was conducted by an APRN and staff were directed to administer a stat (one time dose) of Seroquel (medication used to treat mood disorders) 50 milligrams (mg) Seroquel to the resident for mood and behavior and escalation. A review of the facility Reportable Incident report dated 1/31/2025 identified that a Nursing Assistant student (Person #1) reported on 1/31/2025, Resident #6 came out of the bathroom when Nurse Aide (NA#11) and Person #1 were going to provide care to Resident #6's roommate. Person #1's statement indicated Resident #6 began to kick NA#11, and NA#11 kicked Resident #6 back on the legs. Person #1 reported that NA# 11 called Resident #6 a crazy bitch. The statement further identified NA#11 pushed the resident's wheelchair and scratched the resident's left arm. A statement by NA#11 identified that when NA#11 and Person #1 were providing care to Resident #6's roommate, Resident #6 entered the room and told NA#11 to leave. NA#11 told Resident #6 she was almost done and then would leave. The statement then indicated Resident #6 threw a soiled brief at NA#11, at which point NA#11asked Person #1 to move Resident #6's wheelchair so NA#11 could leave; however, Person #1 was scared, at which time NA#11 moved Resident #6's wheelchair to leave the room. Additionally, the report indicated that on 1-31-25 NA #11 was immediately placed on administrative leave.A statement by NA#13 and NA#14 identified that they took care of Resident #6 on 1/30/2026 and noted no skin impairment. The facility's Reportable Incident report further indicated after completion of the facility's investigation, (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA#11 was terminated.A police report dated 1/31/25 identified NA#11 was interviewed with the help of an interpreter by the police and indicated Resident #6 threw a soiled diaper at NA#11and asked NA#11 to leave. NA #11 continued cleaning Resident #6's roommate after Resident #6 had asked NA#11 to leave and Resident #6 kicked NA#11 on the left and right legs. The report identified NA#11 indicated that it was Person #1 who moved Resident #6's wheelchair out of the way so NA#11 could leave. The police report identified that officers were unable to communicate with Resident #6. The police report further indicated that photographs of the scratches on Resident #6's arm were submitted to the appropriate department by the officers.The social worker note dated 1/31/25 12:30 PM identified the Social Worker (SW) and Administrator met with Resident # 6 regarding reported allegation of abuse. The resident was inconsistent with her/his thoughts and could not recall alleged reported incident. Emotional support was provided and Resident # 6 was encouraged to reach out to staff with any issues /concerns. Appropriate departments were made aware. The Social Worker will update upon new incident.A weekly skin observation tool dated 2/6/2025 identified fading bruises, yellow in color, to the right leg and a fading abrasion to the right lower leg. The skin observation tool further identified fading abraded spots on the left forearm and a fading bruise on the right upper arm.Review of NA #11 employee file noted the summary of the investigation by completed by administration dated 2/11/25 identified NA #11 had been terminated for allegation of witnessed resident abuse , after the resident was found to have skin alteration consistent with alleged incident.On 4/24/2026 at 2:04 PM, an interview with Person #1in their preferred language indicated that Person #1 and NA#11 entered the room to clean Resident #6's roommate when Resident #6 yelled through the bathroom door, which was slightly open to not come in. Person #1 indicated NA#11 opened the bathroom door and NA#11 and Resident #6 began arguing, and NA#11 called Resident #6 a crazy bitch. Resident #6 then threw a soiled diaper at NA#11. Person #1 indicated NA#11 tried to close the bathroom door on Resident #6 and continued calling Resident #6 a crazy bitch. Resident #6 then started kicking NA#11 on the legs, and NA#11 kicked Resident #6 back on Resident #6's right leg. Person #1 further indicated NA#11 was restraining Resident #6 by holding the resident's arm down against the armrest of the wheelchair. Person #1 indicated the main door of the room was closed and she/he was not aware of anybody hearing the incident.On 4/27/2026 at 9:12 AM, an interview with NA#11 using an interpreter of NA#11's choosing (Person #2) indicated NA#11 and Person #1 were changing another resident when Resident #6 came into the room from the bathroom and told NA#11 to get out. NA#11 indicated that she did not leave, and Resident #6 began fighting, stood up from her/his wheelchair, and threw a soiled diaper at NA#11's face. NA #11 indicated Resident #6 was kicking and cursing and she/he (NA#11) sat Resident #6 back in the wheelchair. NA#11 indicated that she/he brought the wheelchair close to Resident #6's and Resident #6 sat her/himself back down while NA#11 held Resident#6's hand for assistance. NA#11 could not recall which of Resident#6's hands she/he held. NA#6 denied calling Resident #6 a crazy bitch, denied kicking Resident #6 on the legs, and denied pushing Resident #6's arms down against the armrests of the wheelchair. NA#11 further indicated that she/he did not ring the call bell or call for help when Resident #6 was agitated and the main door of the room was closed.On 4/27/2026 at 12:34 PM, an interview with the Director of Nursing Services (DNS) identified Person #1 did not have anything to gain from making a false accusation, and Resident #6's injuries did not have another clear cause. The DNS indicated that, out of an abundance of caution, NA#11 was terminated at the conclusion of the facilities investigation.Attempts to interview Resident #6 were unsuccessful as Resident #6 was on medical leave.Resident #6's roommate at the time of the incident (Resident #117) was unable to be interviewed due to severe cognitive impairment.A review of the facility policy for Abuse/ Resident policy updated on 7/23/23 noted abuse shall be defined as willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	age, ability to comprehend or disability. Physical abuse includes hitting, slapping, punching, and kicking. It also includes controlling behavior through corporal punishment.