STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075320	A. Building B. Wing	06/23/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and facility documentation review for one of three residents (Resident #2) reviewed for abuse, the facility failed to ensure the resident was free from misappropriation of resident property. The findings include: Resident #1 had a diagnosis of vascular dementia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 6 indicating severely impaired cognition. The Resident Care Plan (RCP) dated 4/20/26 identified a self-care deficit. Interventions directed Resident #1 was non-ambulatory and dependent for wheelchair mobility, transfer with two (2) assist via mechanical lift, and provide personal care. Record review identified Resident #1 had no physician orders that directed administration of Risperdal (non-opioid medication used to treat bipolar), Trazadone (used to treat depression/not an opioid), Morphine (opioid medication used to treat pain or shortness of breath), or any opioids. Resident #2 had a diagnosis of dementia and was receiving palliative care. Record review identified Resident #2's payment source was Medicaid. Physician order directed liquid Morphine Sulfate (concentrate) oral solution 20 milligrams (mg) per milliliter (ml) give 0.25 ml sublingual (under the tongue) every three (3) hours as needed for shortness of breath. Facility Reportable Event (RE) dated 5/26/26 at 12:33 PM identified Resident #1 was in his/her room when noted unresponsive, and was transferred to the hospital for altered mental status on 5/22/26. Reports from the hospital confirmed urine testing was positive for opiates. Resident #1 was not prescribed any opioid medications. Reportable event summary dated 6/1/26 identified on 5/22/26 about 8:30 AM Resident #1 was noted to be sleepy and was unable to eat breakfast, mental status worsened and a decision was made to send to the resident to the hospital for evaluation. The facility was notified Resident #1 had been treated with Narcan two (2) times and on initial urine screen was positive for opiates. Upon the facility's Medical Directors request, the urine test was repeated, and the results remained positive for opiates. Resident #1 was not prescribed any opioid medications at the facility. The summary indicated, based on interviews and surveillance (video review) there was a possibility that the 11 PM to 7 AM shift nurse (LPN #1) assigned to Resident #1 may have administered narcotic opioid medication that was not ordered by the physician for Resident #1. During an interview with LPN #2, she stated that LPN #1 had indicated to LPN #2 that she had administered Trazadone (used to treat depression/not an opioid) to Resident #1 during the night for agitated behavior. Resident #1 did not have a physician's order for Trazadone. During an interview with LPN #1 she stated she had administered Tylenol to the patient during the night. Tylenol was not documented in the clinical record as administered; no medications were signed as administered during the 11 PM to 7 AM shift prior Resident #1's transfer to the hospital. Interviews failed to identify any staff reported administration of an opioid. Hospital Discharge summary dated [DATE] at 8 AM identified upon admission Resident #1 had myotic (abnormally constricted) pupils. Resident #1 improved after two (2) doses of Narcan, and was started on Bilevel Positive Airway Pressure (BIPAP, ventilator used to assist with breathing). Toxicology results were positive two (2) times for opioids. Resident #1 was admitted for Acute Hypercapnic Respiratory Failure (AHRF) and suspected opioid intoxication despite no opioid prescriptions in the resident's medication list. Record review identified Resident #1 returned to the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075320	A. Building B. Wing	06/23/2026

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	facility on 5/29/26. Review of facility surveillance video identified on 5/22/2026 at approximately 2:30 AM (3 hours and 30 minutes after her shift started), LPN #1 was observed to exit Resident #1's room, go to the medication cart, draw up a medication in a syringe from the medication cart second drawer (non-narcotic drawer). Then LPN #1 obtained a medication from the narcotic box and drew that up in a syringe (using the same syringe), returned the medication box to the drawer and then returned to Resident #1's room with the items she removed from the medication cart in her hands. Record review identified Resident #1 had no medications scheduled for administration during the 11 PM to 7 AM shift, and had no physician orders for any no injections or opioids. Interview and written statement review with LPN #2 on 6/23/26 at 11:18 AM identified she spoke with LPN #1 on 5/23/26 and LPN #1 stated she had enough rest from working 5/21 into 5/22/2026 because she she napped in Resident #1's room during the shift. LPN #2 stated that LPN #1 told her Resident #1 was grunting loudly and interrupting her sleep so bad that she had to give him/her something to sleep. LPN #2 stated that LPN #1 indicated she gave Resident #1 Trazadone 50 milligrams (mg) that belonged to another resident. LPN #2 told LPN #1 that Resident #1 was found unresponsive and LPN #1 stated she did not know nor did she care and that it had nothing to do with her. LPN #2 told LPN #1 that the facility was going to do an investigation and watch the cameras and LPN #1 stated they are going to see me going in and out of the bottle. LPN #2 asked what bottle and LPN #1 stated Risperdal (non-opioid medication used to treat bipolar). LPN #1 further stated she went into the narcotic box to recount because she did not trust the evening shift nurse. LPN #2 advised LPN #1 to come forward, and LPN #1 responded, no and that she was afraid to and she would just say she gave Resident #1 Tylenol. Interview with LPN #1 on 6/22/26 at 2:41 PM identified LPN #1 she was the charge nurse on 5/21/26 into 5/22/26 on the 11 PM to 7 AM shift. LPN #1 stated Resident #1 was agitated and kept trying to climb out of bed by putting his/her feet off the bed so she sat with Resident #1 so he/she would not fall. LPN #1 then stated she told the DNS she gave Resident #1 Tylenol, but stated she did not actually give Resident #1 any medications during her shift, and she stayed in Resident #1's room until 5 AM. LPN #1 stated she was aware the facility had surveillance video and when the video showed her go to the medication cart, she took Morphine (an opioid pain medication) out of the narcotic box. LPN #1 stated she removed the syringe out of the box containing the Morphine bottle because the box was wet from Morphine leaking, and she used the syringe to draw up the Morphine that was in the box, and she then injected it back into the Morphine bottle - LPN #1 stated it was approximately 0.5 to 0.75 ml (10 to 15 mg dosage) that she drew up from the bottom of the box. LPN #1 denied administering any medications to Resident #1 and stated she did not remember what she took out of the first medication cart drawer that she had opened, and she did not remember taking any items with her into Resident #1's room. Record review identified the only liquid medication in the narcotic box was the Morphine concentrate that belonged to Resident #2; Morphine Sulfate (concentrate) oral solution 20 mg per ml. Interview with LPN #4 on 6/23/26 at 12:46 PM identified she worked 5/21/26 from 3 to 11 PM and Resident #1 was at his/her baseline and was not unresponsive. Further, when she counted the narcotics at 11 PM on 5/21/26 with the on-coming nurse, the Morphine bottle was not leaking and the box was not wet. Interview with Person #2 on 6/23/26 at 3:10 PM identified he/she visited Resident #1 on 5/21/26 and left at approximately 8 PM. Person #2 stated that Resident #1 was talkative and awake when he/she left Resident #1. Interview with the DNS on 6/23/26 at 4:40 PM identified the facility surveillance video showed LPN #1 drew up one (1) non-narcotic liquid medication into a syringe and one (1) narcotic liquid medication into the same syringe and then went into Resident #1's room with the items from the medication cart in her hands. The DNS stated nursing staff should not be taking narcotics out of the narcotic box unless they are going to give the medication to the resident which it was prescribed for; residents should not be given any medication that a physician did not order. Review of facility Medication Administration Policy (no date) directed staff medications must be administered only with a valid physician. Review of facility undated Medication Dispensing Policy directed in part, to confirm the medication dose and name are (continued on next page)

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	075320	A. Building B. Wing	06/23/2026

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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	correct, and verify the right resident. Review of facility Abuse Policy dated 7/23/23 directed Abuse to be defined as misappropriation of resident property which means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a residents belongings without the residents consent.

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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 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, observation of facility video, and staff interviews for one of three residents (Resident #1), reviewed for accidents, the facility failed to ensure a resident with dementia that was dependent for personal care and mobility and had no physician orders for opioids was free from exposure to opioids. The resident was identified unresponsive to verbal or tactile stimulation with pinpoint pupils, and was transferred to the hospital where he/she was diagnosed with suspected opioid intoxication, received Narcan, and had two (2) laboratory tests that were positive for opioids, resulting in a finding of Jeopardy. The findings include: Resident #1 had a diagnosis of vascular dementia and history of a stroke (CVA) with hemiparesis and hemiplegia (one sided weakness/paralysis). The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 6 indicating severely impaired cognition, and was dependent with toileting, personal care, and transfers, and was non-ambulatory. The Resident Care Plan (RCP) dated 4/20/26 identified a self-care deficit. Interventions directed Resident #1 was non-ambulatory and dependent for wheelchair mobility, transfer with two (2) assist via mechanical lift, and provide personal care. Nursing Situation Background Assessment Recommendation (SBAR) note dated 5/22/26 at 11:02 AM identified a change in condition. Resident #1 was found in his/her wheelchair unresponsive to verbal or tactile stimulation with flaccid extremities with pinpoint pupils. Nursing note dated 5/22/26 at 11:31 AM identified the APRN was notified Resident #1 was unresponsive to verbal or tactile stimulation with pinpoint pupils with new orders were obtained to transfer Resident #1 to the hospital. APRN note dated 5/22/26 at 7:51 PM identified Resident #1 was unresponsive with a blood pressure of 80/51, respiratory rate of eight (8), oxygen saturation of 88 percent (normal 90% and above), and oxygen was applied via a non-rebreather mask. Resident #1 was transferred to the hospital. Facility Reportable Event (RE) dated 5/26/26 at 12:33 PM identified Resident #1 was in his/her room when noted unresponsive, and was transferred to the hospital for altered mental status on 5/22/26. Reports from the hospital confirmed urine testing was positive for opiates. Resident #1 was not prescribed any opioid medications. Hospital Discharge summary dated [DATE] at 8 AM identified upon admission Resident #1 had myotic (abnormally constricted) pupils. Resident #1 improved after two (2) doses of Narcan, and was started on Bilevel Positive Airway Pressure (BIPAP, ventilator used to assist with breathing). Toxicology results were positive two (2) times for opioids. Resident #1 was admitted for Acute Hypercapnic Respiratory Failure (AHRF) and suspected opioid intoxication despite no opioid prescriptions in the resident's medication list. Reportable event summary dated 6/1/26 identified on 5/22/26 about 8:30 AM Resident #1 was noted to be sleepy and was unable to eat breakfast, mental status worsened and a decision was made to send to the resident to the hospital for evaluation. The facility was notified Resident #1 had been treated with Narcan two (2) times and on initial urine screen was positive for opiates. Upon the facility's Medical Directors request, the urine test was repeated and the results remained positive for opiates. Resident #1 was not prescribed any opioid medications at the facility. The summary indicated, based on interviews and surveillance (video review) there was a possibility that the 11 PM to 7 AM shift nurse (LPN #1) assigned to Resident #1 may have administered narcotic opioid medication that was not ordered by the physician for Resident #1. During an interview with LPN #2, she stated that LPN #1 had indicated to LPN #2 that she had administered Trazadone (used to treat depression/not an opioid) to Resident #1 during the night for agitated behavior. Resident #1 did not have a physician's order for Trazadone. During an interview with LPN #1 she stated she had administered Tylenol to the patient during the night. Tylenol was not documented in the clinical record as administered; no medications were signed as administered during the 11 PM to 7 AM shift prior Resident #1's transfer to the hospital. Interviews failed to identify any (continued on next page)

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	075320	A. Building B. Wing	06/23/2026

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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 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	staff reported administration of an opioid. Record review identified Resident #1 returned to the facility on 5/29/26. Review of facility surveillance video identified on 5/22/2026 at approximately 2:30 AM (3 hours and 30 minutes after her shift started), LPN #1 was observed to exit Resident #1's room, go to the medication cart, draw up a medication in a syringe from the medication cart second drawer (non-narcotic drawer). Then LPN #1 obtained a medication from the narcotic box and drew that up in a syringe (using the same syringe), returned the medication box to the drawer and then returned to Resident #1's room with the items she removed from the medication cart in her hands. Record review identified Resident #1 had no medications scheduled for administration during the 11 PM to 7 AM shift, and had no physician orders for any no injections or opioids. Interview and written statement review with LPN #2 on 6/23/26 at 11:18 AM identified she spoke with LPN #1 on 5/23/26 and LPN #1 stated she had enough rest from working 5/21 into 5/22/2026 because she she napped in Resident #1's room during the shift. LPN #2 stated that LPN #1 told her Resident #1 was grunting loudly and interrupting her sleep so bad that she had to give him/her something to sleep. LPN #2 stated that LPN #1 indicated she gave Resident #1 Trazadone 50 milligrams (mg) that belonged to another resident. LPN #2 told LPN #1 that Resident #1 was found unresponsive and LPN #1 stated she did not know nor did she care and that it had nothing to do with her. LPN #2 told LPN #1 that the facility was going to do an investigation and watch the cameras and LPN #1 stated they are going to see me going in and out of the bottle. LPN #2 asked what bottle and LPN #1 stated Risperdal (non-opioid medication used to treat bipolar). LPN #1 further stated she went into the narcotic box to recount because she did not trust the evening shift nurse. LPN #2 advised LPN #1 to come forward, and LPN #1 responded, no and that she was afraid to and she would just say she gave Resident #1 Tylenol. Interview with LPN #1 on 6/22/26 at 2:41 PM identified LPN #1 she was the charge nurse on 5/21/26 into 5/22/26 on the 11 PM to 7 AM shift. LPN #1 stated Resident #1 was agitated and kept trying to climb out of bed by putting his/her feet off the bed so she sat with Resident #1 so he/she would not fall. LPN #1 then stated she told the DNS she gave Resident #1 Tylenol, but stated she did not actually give Resident #1 any medications during her shift, and she stayed in Resident #1's room until 5 AM. LPN #1 stated she was aware the facility had surveillance video and when the video showed her go to the medication cart, she took Morphine (an opioid pain medication) out of the narcotic box. LPN #1 stated she removed the syringe out of the box containing the Morphine bottle because the box was wet from Morphine leaking, and she used the syringe to draw up the Morphine that was in the box, and she then injected it back into the Morphine bottle - LPN #1 stated it was approximately 0.5 to 0.75 milliliters (ml) that she drew up from the bottom of the box. LPN #1 denied administering any medications to Resident #1 and stated she did not remember what she took out of the first medication cart drawer that she had opened, and she did not remember taking any items with her into Resident #1's room. Interview with LPN #4 on 6/23/26 at 12:46 PM identified she worked 5/21/26 from 3 to 11 PM and Resident #1 was at his/her baseline and was not unresponsive. Further, when she counted the narcotics at 11 PM on 5/21/26 with the on-coming nurse, the Morphine bottle was not leaking and the box was not wet. Interview with Person #2 on 6/23/26 at 3:10 PM identified he/she visited Resident #1 on 5/21/26 and left at approximately 8 PM. Person #2 stated that Resident #1 was talkative and awake when he/she left Resident #1. Record review identified Resident #3 was Resident #1's roommate and had no order for any injectables or liquid Risperdal or liquid Morphine. Resident #3 had a physician order that directed to administer Trazadone 50 mg, half a tablet every morning, and Risperdal 3 mg one (1) tablet at bedtime daily. Interview with the DNS on 6/23/26 at 4:40 PM identified the only two (2) liquid medications in the medication cart on 5/21/26 into 5/22/26 during the 11 PM to 7 AM shift were Risperdal and Morphine, and Resident #1 did not have a physician order for either of those medications. Resident #1 did not have any physician orders for any opioid medications. The facility surveillance video showed LPN #1 drew up one (1) non-narcotic liquid medication into a syringe and one (1) narcotic liquid medication into the same syringe and then went into Resident #1's room with the items from the medication cart in her hands. Interview with MD #1 on (continued on next page)

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	075320	A. Building B. Wing	06/23/2026

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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.

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	6/24/26 at 1:57 PM identified he was Resident #1's primary care physician and was aware of the incident on 5/22/26. MD #1 stated Resident #1 did not have any active order during the time of the incident for any injections, Risperdal, Morphine, Trazadone, or any opioids. MD #1 did not instruct LPN #1 to give any medications to Resident #1 during her shift. MD #1 stated if Resident #1 received Risperdal and Morphine together, the effects of the medication would be obtunded (drowsy and require repeated verbal or light physical stimuli to awaken), drowsiness, potentially unresponsive, pinpoint pupils, decreased respiratory rate, and low blood pressure. MD #1 stated having those signs indicated an opioid overdose. Review of facility Medication Administration Policy (no date) directed staff medications must be administered only with a valid physician order and document in the Medication Administration Record (MAR) immediately after giving the medication. Review of facility Narcotic Count Policy (no date) directed all removals, additions, and remaining balances must be recorded immediately in a perpetual inventory log. Review of facility undated Medication Dispensing Policy directed in part, to confirm the medication dose and name are correct, verify each medication preparation that the medication was the right drug, at the right dose, the right route, the right rate, the right time, for the right resident, and verify the Medication Administration Record (MAR) reflects the most recent medication order. Facility documentation review identified education was initiated on 5/26/26 for all nursing staff and included education on medication administration, physician orders, wasting medication (non-narcotic and narcotic), narcotic count at change of shift, Narcan policy, and signs of opioid toxicity. Medication administration audits were initiated on 5/23/26, narcotic counts and procedure audits were initiated on 5/27/26, and a QAPI meeting was held on 5/27/26. Based on review of facility documentation, past non-compliance was identified.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and facility documentation review for one of three residents (Resident #2) reviewed for abuse, the facility failed to ensure staff followed accepted medication administration practices administration practices. The findings include: Review of facility surveillance video identified on [DATE] at approximately 2:30 AM (3 hours and 30 minutes after her shift started), LPN #1 was observed to exit Resident #1's room, walk down the hallway toward the nursing station with her medication cart keys in her right hand and a black item the size of a cell phone in her left hand. LPN #1 went to the medication cart, placed the cell phone sized item on top of the left side of the med card and she unlocked the cart and placed her keys on top of the right side of the medication cart. Without unlocking or referring to the laptop on the medication cart (med cart) or the Medication Administration Record (MAR), LPN #1 then opened a large non-narcotic drawer and removed an item that appeared to be a small box inside a clear plastic bag and drew up a liquid medication into a syringe. She placed the syringe on the top right side of the med cart and appeared to screw a top onto the medication bottle, replace the bottle into the box and plastic bag, dropped it into the drawer and pushed the drawer shut using her right knee. LPN #1 then opened the top right drawer of the med cart, removed keys from the drawer and closed the top drawer. She then opened the second drawer (under the drawer where she obtained the keys) and used the keys to unlock the drawer. She then pushed medication cards forward in the drawer and reached to the back of the drawer, again without referring to the computer MAR. LPN #1 then removed a box from the drawer and removed a bottle from inside the box and placed the box on the top of the med cart. Using the syringe that was on the top of the med cart she then tipped the bottle upside down and appeared to remove liquid from the bottle. She then looked at they syringe, placed the syringe on the top of the med cart, appeared to screw a cap onto the bottle, placed the bottle into the box, and placed the box in the back of the drawer. LPN #1 then pushed the medication cards so they were leaning towards the back of the drawer and she locked and closed the drawer. LPN #1 then returned the keys into the top right drawer of the med cart, and picked up the syringe and the cell phone sized item and walked down the hall away from the med cart without locking the cart. Interview with LPN #1 on [DATE] at 2:41 PM identified LPN #1 she was the charge nurse on [DATE] into [DATE] on the 11 PM to 7 AM shift. LPN #1 stated she was aware the facility had surveillance video and when the video showed her go to the medication cart, she took Morphine (an opioid pain medication) out of the narcotic box. LPN #1 stated she removed the syringe out of the box containing the Morphine bottle because the box was wet from Morphine leaking, and she used the syringe to draw up the Morphine that was in the box, and she then injected it back into the Morphine bottle - LPN #1 stated it was approximately 0.5 to 0.75 milliliters (ml) that she drew up from the bottom of the box and re-inserted into the medication bottle. LPN #1 denied administering any medications to a resident at that time, and stated she did not remember what she took out of the non-narcotic medication cart drawer that she had opened, and she did not remember taking any items with her into a resident's room at that time. LPN #1 stated she should not have drawn up the Morphine that she stated leaked from the bottle and she should not have put it back into the bottle. LPN #1 stated the narcotic keys should be on her at all times and she did not remember taking them out of the right top drawer of the med cart. Interview failed to identify if she should have referred to the MAR or the narcotic proof of use sheet/disposition record, or if she should have signed for any medications removed from the med cart. Interview with LPN #4 on [DATE] at 12:46 PM identified she worked [DATE] from 3 to 11 PM and when she counted the narcotics at 11 PM on [DATE] with the on-coming nurse (LPN #1), the Morphine bottle was not leaking and the box was not wet. Review of the CT Department of Consumer Protection Drug Control Division Extended Care Facility Recommendations directed in part, the keys to the controlled substance drawer of the medication cart (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	shall be carried personally by the nurse responsible for the required controlled substance audit during each nursing shift. b. Statement from LPN #6 identified on [DATE] at 3 PM while conducing the shift change narcotic count with LPN #1, LPN #6 noted the Morphine box appeared wet with a green-looking solution. LPN #6 informed LPN #1, the off-going nurse who then secured the cap to stop the leak and RN #1 (supervisor) was made aware of the situation. LPN #6 stated RN #1 told LPN #5 and LPN #6 to document the left-over medication and to sign and cosign it. Statement from LPN #5 on [DATE] identified on [DATE] at approximately 3:25 PM while completing narcotic count the Morphine box for Resident #2 was wet and leaking medication. Upon examining the bottle, it was observed the cap to the bottle was not fully secured. LPN #5 secured the cap and notified RN #1 of the situation. RN #1 instructed LPN #1 to document the medication loss as a waste and RN #1 cosigned the documentation. Interview with RN #1 on [DATE] at 2:37 PM identified LPN #5 informed him the box for the Morphine bottle was wet because the cap was loose. After RN #1 checked the Morphine the box was wet, he cosigned the narcotic sheet to indicate what was left in the bottle. RN #1 stated he did not put the amount that was wasted or the time the medication was wasted and just put the amount that was left in bottle. RN #1 stated the reason why he did not put the time or amount wasted because in his mind he was just looking at the amount wasted and it was a busy shift and had admissions to do. RN #1 stated he should have noted the time, and made a notation as to why only 10 ml remained in the bottle. Interview with the DNS on [DATE] at 4:40 PM identified she did not see an amount identified on the narcotic sheet that was wasted or a time that the waste occurred. The DNS stated she did not know why nursing did not document the time or amount wasted but stated it should have been documented c. Review of the proof of use sheet/disposition record serial #1325225 for Morphine solution identified 30 millimeters (ml) were received on [DATE], and the orders were to administer 0.25 ml every three (3) hours as needed for shortness of breath. An entry dated 4/15 and indicated 0.25 ml was administered, with 28 ml left in the bottle. The next entry was dated 5/23 with no time or amount given noted, the nurse signature was illegible, and the amount left was 10. To the right of the #10 was written wasted with a signature that was illegible. Additional review failed to identify the time the medication was wasted, and the amount that was wasted. Interview and record review with the DNS on [DATE] at 4:40 PM identified when a narcotic medication is wasted/discarded, two (2) nurses are required to sign, and the time and amount that is wasted are required to be noted. Interview identified the illegible signatures belonged to RN #1 and the second nurse was unable to be identified. Review of the facility undated Narcotic Count Policy directed all removals must be recorded immediately on the inventory log. d. Interview and record review with the DNS on [DATE] at 4:40 PM identified when controlled medications are received from the pharmacy they come with a white disposition record that the nurses on the unit use to sign that they administered a medication. In addition, a copy (yellow proof of use sheet) is received at the same time. The DNS stated she performed narcotic audits bi-monthly (twice a month) using a facility made/created form. Review of the form identified it listed the unit and the medication cart audited. The audit included the following seven (7) yes or no questions:1.Was the med cart locked before audit?2.All meds have a proof of use sheet.3.Current count correct.4.All change of shift count sheets signed without blanks.5.All med labeled correctly.6.Expiration dates checked.7.No expired meds.Additional review of the audit form failed to identify the individual controlled medication sheets/disposition sheets were compared and reconciled to the yellow copy proof of use sheet received when the medication was delivered from the pharmacy to ensure all controlled medications were present in the box and the individual counts were accurate. The DNS stated she did not reference and/or compare the white disposition sheets to the original copy of the proof of use/disposition record when completing the audits to compare or note what the original drug amount was that was received and what the prior audited amount was, and to ensure no controlled medications were missing from the narcotic box. Interview failed to identify why narcotic audits did not include reconciliation with the pharmacy provided copy of the proof of use sheets to ensure all (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075320	A. Building B. Wing	06/23/2026

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	medications were accounted for. Interview with the DNS on [DATE] at 4:40 PM identified the facility surveillance video showed LPN #1 drew up one (1) non-narcotic liquid medication into a syringe and one (1) narcotic liquid medication into the same syringe and then went into Resident #1's room with the items from the medication cart in her hands. The DNS stated staff should sign for controlled medications when they are removed from the narcotic box, and the narcotic box keys should be carried by the charge nurse, physician orders and the MAR should be checked to verify orders prior to medication administration, medications should be signed for when they are administered by the nurse, the time and amount of any narcotic medication should be noted when wasted, and bi-monthly audits should include verification that all controlled medications are in the narcotic box. Review of the CT Department of Consumer Protection Drug Control Division Extended Care Facility Recommendations directed in part, the keys to the controlled substance drawer of the medication cart shall be carried personally by the nurse responsible for the required controlled substance audit during each nursing shift. The Director of Nursing or designee shall conduct bi-monthly audits of all controlled substances. Required destruction records shall be maintained whenever partial or individual doses of controlled substance stock are discarded by nursing personnel and must indicate: a. Name, form, strength and quantity of the controlled substance b. Signature of another nurse witnessing such destruction. Review of the undated facility Medication Administration Policy directed staff medications must be administered only with a valid physician order and document in the Medication Administration Record (MAR) immediately after giving the medication. Review of the undated facility Narcotic Count Policy directed all removals, additions, and remaining balances must be recorded immediately in a perpetual inventory log. Review of facility undated Medication Dispensing Policy directed in part, to confirm the medication dose and name are correct, verify each medication preparation that the medication was the right drug, at the right dose, the right route, the right rate, the right time, for the right resident, and verify the Medication Administration Record (MAR) reflects the most recent medication order. Review of undated facility Narcotic Count Policy directed all removals, additions, and remaining balances must be recorded immediately in a perpetual inventory log.