STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075296	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Branford Hills	189 Alps Road Branford, CT 06405

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for medication administration, the facility failed to ensure the provider was notified for each missed administration of insulin. The findings include:Resident #1's diagnoses included type 2 diabetes mellitus, end stage renal disease and morbid obesity. Review of the hospital Discharge summary dated [DATE] directed to administer Humulin R U-500 injectable pen 40 units daily before dinner. A physician's order dated 7/21/25 directed to administer Humulin R U-500 units per milliliter (concentrated) inject 40 units subcutaneously in the evening. The admission Nursing assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, time and situation. The Resident Care Plan dated 7/23/25 identified Resident #1 has a diagnosis of diabetes and was at risk for hyperglycemia (elevated blood sugar) and/or hypoglycemia (low blood sugar). Interventions included administering medications as ordered. A physician's order dated 7/22/25 directed to discontinue the Humulin R U-500 units per milliliter (concentrated) inject 40 units subcutaneously in the evening and to administer Humulin-R insulin 100 units per milliliter (u/mL), inject 40 units subcutaneously every evening for type 2 diabetes mellitus. Review of the July 2025 Medication Administration Record (MAR) identified the Humulin-R insulin was not administered on 7/22/25, 7/24/25, 7/25/25 and 7/26/25 and referenced to see the progress notes. Upon further review of the MAR the Humulin-R insulin was noted to be signed off as administered on 7/23/25. The Electronic Medication Administration Record note dated 7/22/25 identified the Humulin-R insulin was on order. There was no documentation identifying the nursing supervisor, provider or pharmacy were notified of the missed administration of the Humulin-R insulin on 7/22/25. The nurse's note dated 7/24/25 at 8:21 PM identified the 7AM-7PM nursing supervisor, Registered Nurse (RN) #6, was called to the unit to help the charge nurse, RN #9, locate Resident #1's Humulin-R insulin. The note indicated after searching and unable to locate the insulin, the Advanced Practice Registered Nurse (APRN) was updated and the APRN directed to hold the 7/24/25 dose, follow-up with the pharmacy and obtain blood sugars three (3) times daily prior to meals and notify a provider if the blood sugar was greater than 400. The note indicated Resident #1's blood sugar at 6:44 PM was 273. The Electronic Medication Administration Record note dated 7/25/25 identified the Humulin-R insulin was not available. The note failed to reflect documentation the nursing supervisor, provider or pharmacy were notified of the missed administration of the Humulin-R insulin on 7/25/25. The Electronic Medication Administration Record note dated 7/26/25 identified the Humulin-R insulin was not available. The note failed to reflect documentation the nursing supervisor, provider or pharmacy were notified of the missed administration of the Humulin-R insulin on 7/26/25. Interview with APRN #1 on 8/25/25 at 11:35 AM identified he was unaware Resident #1 had not received the Humulin-R insulin multiple times until after Resident #1 had already been discharged . APRN #1 explained although Resident #1's blood sugars were stable, a provider should have been notified for each missed administration for a possible alternative order. APRN #1 stated the pharmacy should have been contacted to inquire about the medication's whereabouts. Review of the blood sugar documentation for Resident #1 identified a range from 165 to 273. Interview with the pharmacy technician on 8/25/25 at 1:10 PM identified the Humulin-R insulin 100 u/mL was not filled. Interviews with the charge nurses, Licensed Practical Nurse (LPN) #1 and LPN #2, on 8/25/25 identified they did not notify the nursing supervisor, the provider or call the pharmacy when the doses of Humulin-R insulin 100 u/mL were not administered to Resident #1 on 7/22/25, 7/25/25 or 7/26/25. They identified they were not aware they had to notify the nursing supervisor for each missed administration so that the nursing supervisor could contact the provider for possible alternative orders and they identified Humulin-R insulin was not available in the facility's emergency stock medication. Interview with LPN #3 on 8/25/25 at 3:30 PM identified she signed off the Humulin-R insulin was administered to Resident #1 on 7/23/25 when it had not yet arrived from the pharmacy. LPN #3 identified if the medication was unavailable for administration, she should have called the pharmacy to check on the status and then notified the supervisor of the missed administration and documented the conversations in the clinical record. Interviews with Registered Nurse (RN) #6, RN #7, and RN #8 on 8/25/25 identified they could not recall being notified by LPN #1, LPN #2 or LPN #3 on 7/22/25, 7/23/25, 7/25/25 or 7/26/25 that Resident #1's Humulin-R insulin was not available, explaining if they had, they would have notified the provider, wrote a note to identify the notification and any new orders that were obtained. RN #6 reported although she wrote the note on 7/24/25 identifying she was going to follow-up with

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Residents #1) who was a new admission and reviewed for medication orders, the facility failed to collaborate with the pharmacy to ensure a medication was clarified and delivered to the facility to prevent the resident from missing four (4) days of insulin. The findings include:Resident #1's diagnoses included type 2 diabetes mellitus, end stage renal disease and morbid obesity. Review of the hospital Discharge summary dated [DATE] directed to administer Humulin R U-500 injectable pen 40 units daily before dinner. A physician's order dated 7/21/25 directed to administer Humulin R U-500 units per milliliter (concentrated) inject 40 units subcutaneously in the evening. The admission Nursing assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, time and situation. The Resident Care Plan dated 7/23/25 identified Resident #1 has a diagnosis of diabetes and was at risk for hyperglycemia (elevated blood sugar) and/or hypoglycemia (low blood sugar). Interventions included administering medications as ordered. A physician's order dated 7/22/25 directed to discontinue Humulin R U-500 units per milliliter (concentrated) inject 40 units subcutaneously in the evening and administer Humulin-R solution 100 units per milliliter (u/mL), inject 40 units subcutaneously every evening for type 2 diabetes mellitus. Review of the July 2025 Medication Administration Record (MAR) identified the Humulin-R insulin was not administered on 7/22/25, 7/24/25, 7/25/25 and 7/26/25 and referenced to see the progress notes. Upon further review of the MAR the Humulin-R insulin was noted to be signed off as administered on 7/23/25. The Electronic Medication Administration Record note dated 7/22/25 identified the Humulin-R insulin was on order. There was no documentation identifying the nursing supervisor, the provider or pharmacy were notified of the missed administration of Humulin-R insulin on 7/22/25. The nurse's note dated 7/24/25 at 8:21 PM identified the 7AM-7PM nursing supervisor, Registered Nurse (RN) #6 was called to the unit to help the charge nurse, RN #9, locate Resident #1's Humulin-R insulin. The note indicated after searching and unable to locate the insulin, the Advanced Practice Registered Nurse (APRN) was updated and the APRN directed to hold the 7/24/25 dose, follow-up with the pharmacy and obtain blood sugars three (3) times daily prior to meals and notify a provider if the blood sugar is greater than 400. The note indicated Resident #1's blood sugar at 6:44 PM was 273. Review of the Electronic Medication Administration Record notes dated 7/25/25 and 7/26/25 identified the Humulin-R insulin was not available. The notes failed to reflect documentation the nursing supervisor, provider, or pharmacy were notified of the missed administration of Humulin-R insulin. Interview with the pharmacy technician on 8/25/25 at 1:10 PM identified the Humulin-R insulin 100 u/mL was not filled. Interview with the pharmacist on 8/25/25 at 1:37 PM identified the original order entered on admission 7/21/25 for Resident #1 was for Humulin R U-500 (a highly concentrated insulin, five times stronger than standard U-100 insulin which requires careful administration to avoid dangerous dosing errors) and the order was unusual and needed to be clarified with the provider prior to being filled. The pharmacist explained they are an in-house pharmacy at the facility and after hours there is a back-up pharmacy. The pharmacist stated on 7/21/25 he had asked the back up pharmacy to look into clarifying the Humulin R U-500 order, he did not hear anything about it again and was unaware a new order had been entered for Humulin-R insulin 100 u/ml. The pharmacist identified he was not sure how he missed the new order, stating it the 7/22/25 order that was not filled. Interview with the Director of Nursing (DON) on 8/25/25 at 1:48 PM identified the facility depends on the pharmacy to provide delivery of medications and the nursing staff should have followed up with the pharmacy each time it was identified the insulin was not available

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility policy and interviews for one (1) of three (3) sampled residents (Residents #1) reviewed for medication administration, the facility failed to document in the clinical record when the medication was not available and what interventions were initiated. The findings include: Resident #1's diagnoses included type 2 diabetes mellitus, end stage renal disease and morbid obesity. Review of the hospital Discharge summary dated [DATE] directed to administer Humulin R U-500 injectable pen 40 units daily before dinner. A physician's order dated 7/21/25 directed to administer Humulin R U-500 units per milliliter (concentrated) inject 40 units subcutaneously in the evening. The admission Nursing assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, time and situation. A physician's order dated 7/22/25 directed to discontinue Humulin R U-500 units per milliliter (concentrated) inject 40 units subcutaneously in the evening and administer Humulin-R insulin 100 units per milliliter (u/mL), inject 40 units subcutaneously every evening for type 2 diabetes mellitus. Review of the July 2025 Medication Administration Record (MAR) identified the Humulin-R solution was not administered on 7/22/25, 7/24/25, 7/25/25 and 7/26/25 and to see the progress notes. Upon further review of the MAR the Humulin-R solution was noted to be signed off as administered on 7/23/25. The Electronic Medication Administration Record note dated 7/22/25 identified the Humulin-R solution was on order. There was no documentation identifying the nursing supervisor, the provider or pharmacy were notified of the missed administration of Humulin-R solution on 7/22/25. The nurse's note dated 7/24/25 at 8:21 PM identified the 7AM-7PM nursing supervisor, Registered Nurse (RN) #6 was called to the unit to help the charge nurse, RN #9, locate Resident #1's Humulin-R Insulin. The note indicated after searching and unable to locate the insulin, the Advanced Practice Registered Nurse (APRN) was updated and the APRN directed to hold the 7/24/25 dose, follow-up with the pharmacy and obtain blood sugars three (3) times daily prior to meals and notify a provider if the blood sugar is greater than 400. The note indicated Resident #1's blood sugar at 6:44 PM was 273. Review of the Electronic Medication Administration Record notes dated 7/25/25 and 7/26/25 identified the Humulin-R insulin was not available. The notes failed to reflect documentation the nursing supervisor, provider, or pharmacy were notified of the missed administration of Humulin-R insulin.Interview with the Director of Nursing (DON) on 8/25/25 at 1:48 PM identified the nurses are expected to document accurately in the clinical record. Review of the Documentation policy dated 6/2023 directed, in part, that all nursing staff are required to complete their documentation to reflect any care and services provided to the residents, which includes EMAR, Treatment Administration Record (TAR), nursing notes, nursing assessments, vital signs and care plan updates/revisions.