STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075338	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Governor's Ho	36 Firetown Rd Simsbury, CT 06070

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 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. (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 0686 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 review of the clinical record, facility documentation, facility policy, and interviews for 2 of 3 residents (Resident #2 and 3) reviewed for pressure injuries (ulcers), the facility failed to ensure Braden scale assessments and weekly skin checks were documented and completed per facility policy. The findings include:1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease and dementia.The Braden scale assessment dated [DATE] identified Resident #2 was at moderate risk for developing pressure injuries.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had moderate impairment in cognition (Brief Interview for Mental Status (BIMS) score of 10), had one (1) unstageable pressure injury, and was at risk for developing pressure injuries.A physician's order dated 4/4/25 directed weekly skin checks.The Braden scale assessment dated [DATE] identified Resident #2 was at risk for developing pressure injuries.The care plan dated 4/9/25 identified Resident #2 had multiple pressure injuries. Interventions included to assess risk of skin breakdown using the Braden scale assessment per policy and check skin at least weekly on scheduled bath day.Review of the medical record failed to identify a Braden scale assessment was completed weekly during the first month of admission (for two out of four opportunities on 4/12/25 and 4/19/25).3. Resident #3 was admitted to the facility on [DATE] with diagnoses that included stroke, type II diabetes and gastrostomy.The care plan dated 1/7/25 identified Resident #3 had the potential for alteration in skin related to decreased mobility, diabetes and incontinence. Interventions included Braden scale assessment completed on admission and per facility skin protocol.The Braden scale assessment dated [DATE] identified Resident #3 was at risk of developing pressure ulcers/injuries.The re-entry skin check dated 1/31/25 identified Resident #3's skin was intact. The medical record failed to identify a skin check was completed for the week of 2/9/25 to 2/15/25.The Braden scale assessment dated [DATE] and 2/14/25 identified Resident #3 was at risk of developing pressure ulcers/injuries.Review of the medical record failed to identify a Braden scale assessment was completed weekly during the first month of admission (for one out of four opportunities on 2/21/25).The skin check dated 2/16/25 identified Resident #3 had no injuries after a fall.The medical record failed to identify a skin check was completed for the weeks of 2/23/25 to 3/1/25, 3/2/25 to 3/8/25, 3/9/25 to 3/15/25 and 3/16/25 to 3/22/25.The weekly wound evaluation dated 3/24/25 identified Resident #3 had a coccyx pressure injury measuring 1 centimeter (cm) by .5 cm by .1 cm. The weekly wound evaluation failed to identify a full body skin check was conducted.The weekly wound evaluation dated 3/31/25 identified Resident #3 had a coccyx pressure injury measuring 1 cm by .5 cm by .1 cm. The weekly wound evaluation failed to identify if a full body skin check was conducted.The skin check dated 4/4/25 identified Resident #3's skin was intact. The skin check failed to identify the status of Resident #3's coccyx pressure injury, and a weekly wound evaluation was not documented.The weekly wound evaluation dated 4/7/25 identified Resident #3 had a coccyx pressure injury measuring .5 cm by .2 cm by .1 cm.Interview with the DNS on 5/5/25 at 3:00 PM identified Braden scale assessments (risk evaluations) are to be completed per facility policy on admission/readmission, weekly for the first month, quarterly, and with a significant change. If there is a new skin concern identified, then a skin check form should be completed. She identified a weekly wound evaluation should be completed weekly for resident's with an existing wound and a separate skin check form should be completed for the weekly skin check (or documented in the TAR).Review of the skin integrity management policy directed to complete a risk evaluation on admission/readmission, weekly for the first month, quarterly, and with significant change in condition. Perform skin inspections (checks) on admission/readmission and weekly. Document on the TAR or in the electronic medical record. Perform wound observations and measurements and complete the skin observation tool upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound.Review of the nursing documentation policy directed that documentation should be completed as soon as possible after care is provided, assessments are conducted, or any significant event occurs, ideally within the same shift. All entries must be factual, complete, and reflect the resident's current condition and care provided.