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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Governor's Hous	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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on review of the clinical record, facility policy and interviews for 1 of 1 sampled residents (Resident #19) reviewed for dental, the facility failed to report missing dentures to afford the opportunity for Resident #19 to submit a grievance. Resident 19's diagnosis included unspecified sequelae of cerebral infarction, paroxysmal atrial fibrillation and Type 2 diabetes mellitus. The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 was independent with eating, required supervision or touching assistance for oral hygiene, substantial/ maximal assistance for toileting hygiene, substantial/ maximal assistance for showering, partial/ moderate assistance for lower body dressing, supervision or touching assistance for upper body dressing. On 3/4/24 at 11:00 AM, interview with Resident #19 identified that his/her upper dentures were missing for about a week and could not recall if he/she told anyone. Interview with Licensed Practical Nurse (LPN) #1 on 3/4/24 at 12:07 PM identified that she was unaware that Resident #19's top dentures were missing. Interview with Social Worker (SW) #1 on 3/4/24 at 12:15 PM identified that he was unaware, and it was not reported to him that Resident #19's top dentures were missing. Interview with Nurse Aide (NA) #1 on 3/4/24 at 12:21 PM identified that although she noticed Resident #19's upper dentures were missing, she did not report the missing denture to licensed staff or the SW because she thought someone had already reported it. Although NA #1 was aware of Resident #19's missing upper dentures, she did not report to facility staff in order for a grievance to be initiated to resolve the missing denture.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024
NAME OF PROVIDER OR SUPPLIER: Ark Healthcare & Rehabilitation at Governor's Hous		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 Firetown Rd Simsbury, CT 06070	

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on review of the clinical record and interviews for 4 of 4 sampled residents (Resident #18, Resident #19, Resident #43 and Resident #59) reviewed for hospitalization , the facility failed to provide the required notification of transfer/discharge to the state Ombudsman's office. The findings include: 1. Resident #18 diagnoses included Parkinson's disease with dyskinesia, pneumonitis, cognitive communication deficit. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 was severely cognitively impaired, required extensive assistance of 2 for bed mobility, total dependence for transfers, and total dependence for dressing and toilet use. Nursing notes dated 9/9/23 at 4:26 PM written by Registered Nurse (RN) #8 identified Resident #18 pulled his/her Percutaneous Endoscopic Gastrostomy (PEG) tube out, the on call provider was notified and Resident #18 was transported to the hospital. Advanced Practice Registered Nurse (APRN) #1 progress notes dated 9/13/23 at 10:31 AM identified Resident #18 was hospitalized from 9/9/23 until 9/13/23, underwent a PEG tube placement on 9/12/23 and was sent back to the facility on [DATE]. Review of the clinical record failed to identify documentation that the State Ombudsmen's office was notified of the residents transfer to the hospital. 2. Resident #19's diagnosis included unspecified sequelae of cerebral infarction, paroxysmal atrial fibrillation, and Type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 had intact cognition, required set-up or clean up assistance for oral hygiene, substantial/maximal assistance for toileting, supervision or touching assistance with upper body dressing, and substantial/maximal assistance with lower body dressing. Nursing notes dated 10/18/23 at 11:01 AM and written by the Director of Nursing (DNS) identified Resident #19 reported mid-sternal chest pain, dull in nature; vital signs were obtained, slight expiratory wheeze, with course lung sounds. The nursing notes further identified Resident #19 was assessed by the physician and a new order was obtained to transfer Resident #19 to the hospital. Nursing notes dated 10/31/23 as a late entry identified Resident #19 was admitted to the hospital from 10/18/23 to 10/29/23. Review of the clinical record failed to identify documentation that the State Ombudsmen's office was notified of the transfer to the hospital. 3. Resident #43's diagnoses included dementia, weakness, and a connective tissue disorder. (continued on next page)

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

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	The annual Minimum Data Set assessment dated [DATE] identified Resident #43 was severely cognitively impaired, needed substantial assistance of 1 staff for toileting, and could ambulate 150 feet independently. A physician's note dated 2/14/24 documented that Resident #43 was transferred to the hospital on 2/10/24 and returned to the facility on [DATE]. Interview and review of the facility Ombudsman transfer list with Social Worker #1 on 3/4/24 at 10:15 AM failed to identify documentation that the State Ombudsmen's office was notified of the transfer to the hospital. 4. Resident #59 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, acute cholecystitis, sepsis, and dementia. The admission Minimum Data Set assessment dated [DATE] identified Resident #59 was moderately cognitively impaired and required maximum assistance with toileting, personal hygiene, and partial to moderate assistance to reposition in bed. Nursing notes dated 2/17/24 at 6:53 PM identified Resident #59 was having pain to the right side of the abdomen and had a right-hand tremor. The physician was notified and directed to send Resident #59 to the hospital. Review of the clinical record failed to identify documentation that the State Ombudsmen Office was notified of Resident #59's admission/transfer to the hospital. Interview and record review with Social Worker (SW) #1 on 3/4/24 at 10:15 AM identified that although he was aware of the requirement to notify the State Ombudsmen's Office with hospital transfers, he had not done so. Additionally, SW #1 identified he received a list of transfers from the electronic health record system, generated a report for the Ombudsmen's Office, but could not ascertain the reason Resident #18, Resident #19, Resident #43 and Resident #55 did not appear on the list. Although requested, a facility policy for notification of the ombudsman when a resident is admitted to the hospital was not provided. 50095 50250

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for 4 of 5 residents (Resident #18, Resident #19, Resident #55, and Resident #59) reviewed for hospitalization , the facility failed to provide documentation that the facility bed hold notice was provided to the resident or resident representative upon hospitalization . The findings include: 1. Resident #18 diagnoses included Parkinson's disease with dyskinesia, pneumonitis, cognitive communication deficit. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 severely cognitively impaired, required extensive assistance of 2 for bed mobility, total dependence for transfers, and total dependence for dressing and toilet use. Nursing notes dated 9/9/23 at 4:26 PM identified Resident #18 pulled his/her Percutaneous Endoscopic Gastrostomy (PEG) tube out, the on call provider was notified and Resident #18 was transported to the hospital. APRN #1 progress note dated 9/13/23 at 10:31 AM identified Resident #18 was hospitalized from 9/9/23 until 09/13/23, underwent a PEG tube placement on 9/12/23 and was sent back to the facility on [DATE]. Review of the clinical record failed to identify documentation that the resident/responsible party was notified of the bed hold policy. 2. Resident #19 diagnoses included unspecified sequelae of cerebral infarction, paroxysmal atrial fibrillation, and Type 2 diabetes mellitus. An Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 had intact cognition, required set-up or clean up assistance for oral hygiene, substantial/maximal assistance for toileting, supervision or touching assistance with upper body dressing, and substantial/maximal assistance with lower body dressing. Nursing notes dated 10/18/23 at 11:01 AM and written by Director of Nursing (DNS) identified Resident #19 reported mid-sternal chest pain, dull in nature; vital signs were obtained, slight expiratory wheeze, course lung sounds. The nursing notes further identified Resident #19 was assessed by the physician and a new order was obtained to transfer Resident #19 to the hospital. Nursing notes dated 10/31/23 as a late entry identified Resident #19 was admitted to the hospital from 10/18/23 to 10/29/23. Review of the clinical record failed to identify documentation that the resident/responsible party was notified of the bed hold policy. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Interview with the Social Worker (SW #1) identified that he does not contact the family about the bed hold policy and that would be the responsibility of the admissions and business office. Interview with Business Office Manager (BOM) on 3/5/24 at 10:04 AM identified that Admissions is responsible for entering the bed hold and Ombudsman notifications into the system. He stated that is not part of his responsibilities. Interview with the Admissions Director on 3/4/24 at 10:25 AM identified that residents sign the bed hold policy on admission and the admissions office calls updating the family on the bed hold policy but does not document in the residents medical record that the resident or resident representative has been updated. Review of the Bed Hold Notice policy directed, in part, that should a resident experience a transfer from the facility, a copy of the bed hold policy is provided to the resident at the time of transfer. Within 24 hours of the resident's transfer, the Business Office Manager/designee will telephone the resident or resident's known agent notifying them of the bed hold option. This conversation shall be documented in the resident's medical record. 3. Resident #55's diagnoses included chronic obstructive pulmonary disease, heart failure, and respiratory failure. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 was moderately cognitively impaired and required set up assistance for eating, moderate assistance for transfers, and was independent for bed mobility. Review of the Hospital Transfer Forms in the clinical record identified Resident #55 was sent to the hospital on 1/13/24, 1/27/24 and 3/1/24. Review of the clinical record failed to identify documentation that the resident/responsible party was notified of the bed hold policy. Review of the Resident Bed Hold Documentation Form from the facility's binder identified Resident #55 had a form filled out for the 1/24/24 and 3/1/24 hospitalization s, but they were not signed/dated by the resident or resident representative, nor was there any documented confirmation on the form that the facility received a verbal/telephone decision on the bed hold. There was no form for the 1/13/24 hospitalization in the facility's Resident Bed Hold binder. 5. Resident #59's diagnoses included acute cholecystitis, sepsis, and dementia. The admission Minimum Data Set assessment dated [DATE] identified Resident #59 was moderately cognitively impaired and required maximum assistance with toileting, personal hygiene, and partial to moderate assistance to reposition in bed. Nursing note dated 2/17/24 at 6:53 PM identified Resident #59 was having pain to the right side of the abdomen and a right-hand tremor. The physician was notified, directed to send Resident #59 to the hospital, and the resident representative was notified. Review of clinical record failed to identify a copy of the signed bed hold notification form. (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 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Interview with Social Worker #1 on 3/4/24 at 10:15 AM identified that he does not contact the family about the bed hold policy and that would be the responsibility of admissions and the business office. Interview with Business Office Manager on 3/5/24 at 10:04 AM identified that admissions is responsible for contacting the resident/resident representative regarding bed holds and entering the bed hold notifications into the system. He stated that he has never done that and it is not part of his responsibilities. Interview with the facilities Administrator and Admissions Assistant on 3/5/24 at 12:53 PM identified that the facility had bed hold policy forms in their initial admissions packet which were normally signed by the resident/resident representative on admission. The Administrtor and Admissions Assistant stated that when the physician directed Resident #59 be sent to hospital on 2/17/24, the responsible party was present and the facility inquired if s/he wanted to change the bed hold status. Although the facility asked the responsible party about bed hold status, they failed to provide a written notice, document the bed hold status in the clinical record, or have the responsible party sign the notice. The facility was unable to explain why they did not follow their bed hold policy. Review of the Bed Hold Notice and Readmission Process policy directed, in part, that should a resident experience a transfer from the facility, a copy of the bed hold policy is provided to the resident at the time of transfer. Additionally, admissions will follow up with a phone call to resident/responsible party to verify the bed hold. Complete the facility Bed Hold Notice, which shall have the resident's name, facility name, and the date of transfer entered onto this notice. The copy of the resident specific and dated bed hold notice is placed into the resident's medical record. Also, within 24 hours of the resident's transfer, the Business Office Manager/designee will telephone the resident or resident's known agent notifying them of the bed hold option. This conversation shall be documented in the resident's medical record. 50094 50095 50250

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility policy, and interviews for 2 of 5 sampled residents (Resident #2 and Resident #58) reviewed for unnecessary medications, the facility failed to initiate a Resident Care Plan related to a diagnosis with corresponding medication use. The findings include: 1. Resident #2's diagnoses included Atrial Fibrillation (A-fib), dementia, and hypothyroidism. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired and required assistance with ADL'S, meals, and medications. A physician's order dated 10/2/23 directed to administer Apixaban 2.5 milligram (mg) twice a day for atrial fibrillation (A-fib). Review of the Resident Care Plan (RCP) failed to identify a problem reflecting Resident #2's A-fib or the use of an anticoagulant medication (blood thinner). Interview and review of the clinical record with Registered Nurse (RN) #1 on 3/4/24 at 9:03 AM identified that there was not a RCP for the anticoagulant medication, and she must have missed adding the problem for Resident #2's anticoagulant medication use. Subsequent to surveyor inquiry, RN #1 indicated that the RCP would be revised to include the use of the anticoagulant medication. 2. Resident #58 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, morbid obesity, and Raynaud's syndrome. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 was cognitively intact and required moderate assistance for transfers, maximum assistance for toileting, and setup assistance for personal hygiene. A physician's order dated 2/19/24 at 9:28 AM directed Resident #58 be administered Toujeo 50 units subcutaneously daily, and Mounjaro 5 milligrams subcutaneously every 7 days (both medications for diabetes). Review of the Resident Care Plan (RCP) failed to identify a care plan for Resident #58's diabetes or diabetic medication use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with RN #1 on 3/4/24 at 12:22 PM, failed to identify Resident #58's had a RCP for his/her diabetes or for the use of diabetic medications. RN #1 identified that RN supervisors were responsible to initiate a RCP for pertinent diagnosis and medications upon admission but had not done so for Resident #58's diabetes. Additionally, a Resident Care Conference (RCC) had been held on 2/26/24 and although the interdisciplinary team was present, no one had initiated, updated, or identified the missing RCP for diabetes or diabetic medication use. RN #1 indicated that RCC's are used to review and revise the care plan so the missing RCP information should have been identified at that time, and that subsequent to surveyor inquiry a diabetic RCP would be generated. Review of the Care Planning policy directed, in part, that a comprehensive care plan for each resident is developed within 7 days of completion of the resident assessment. 50059

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50177 Based on observation, review of the clinical record, facility policy, facility documentation, and interviews for 1 of 4 sampled residents reviewed for accidents (Resident #15), the facility failed to revise the Resident Care Plan regarding discontinuation of anti-embolism stocking and initiation of interventions following a fall. The findings include: Resident #15's diagnoses included dementia, history of falling, and difficulty walking. a. A physician's order dated 4/7/22 through 3/1/23 directed Resident #15 was independent with bed mobility, wheelchair mobility, transfers, and ambulation with rollator within the facility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was moderately cognitively impaired, was independent with walking, and required partial/moderate assistance with sit to lying and sit to stand. The Resident Care Plan (RCP) dated 1/17/23 identified Resident #15 was at risk for falls and that Resident #15 had limited physical mobility. Interventions included a dycem to the wheelchair cushion, call bell within reach, encourage resident to wear nonskid socks over his/her stockings, and that the resident was independent with rollator or wheelchair for transfers and ambulation within the facility. A Reportable Event form dated 2/24/23 at 7:10 PM identified Resident #15 had a witnessed fall with severe pain and he/she was sent to the hospital for evaluation. Resident #15 was hospitalized [DATE] through 2/28/23 for a fall with left hip fracture and had surgery completed. Resident #15 was readmitted to the facility on [DATE]. A physician's order dated 3/3/23 through 4/15/23 directed Resident #15 was to wear Thrombo-Embolus Deterrent (Ted) stockings daily for 6 weeks. The RCP dated 3/3/23 identified that Resident #15 was to have [NAME] stockings on in the morning and removed in the evening. Observation on 2/29/24 at 9:17 AM identified that Resident #15 was not wearing [NAME] stockings. Interview and observation with LPN #1 on 3/1/24 at 12:25 PM identified that Resident #15 was wearing regular stockings and did not wear [NAME] stockings anymore. Interview with NA #3 on 3/1/24 at 12:50 PM also identified that Resident #15 wore regular stockings and did not wear [NAME] stockings. An interview and RCP review with the MDS Coordinator (RN #1) on 3/4/24 at 12:07 PM identified that [NAME] stockings remained on the RCP even though there was no current physician's order and Resident #15 no longer utilized them. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor's inquiry, the intervention for [NAME] stockings was removed from the RCP. b. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was cognitively intact and required supervision or touch assistance with walking, sit to lying, and sit to standing. A physician's order dated 5/16/23 through 9/1/23 directed Resident #15 was independent with bed mobility, independent with a 4 wheeled walker for transfers, independent with a 4 wheeled walker for ambulation on level surfaces and supervision on uneven surfaces. The Resident Care Plan (RCP) dated 5/24/23 identified Resident #15 was at risk for falls and that Resident #15 had limited physical mobility. Interventions included a dycem to the wheelchair cushion, call bell within reach, encourage resident to wear nonskid socks over his/her stockings, and that the resident was an assist of 1 for bed mobility, and an assist of 1 with a 4 wheeled walker for both transfers and ambulation. A Reportable Event form dated 7/5/23 at 11:40 AM identified Resident #15 had an unwitnessed fall with severe pain after falling out of his/her wheelchair and he/she was sent to the hospital for evaluation. A nurse's note dated 7/7/23 at 10:00 PM identified that Resident #15 was readmitted to the facility. The Summary Report dated 7/7/23 and submitted to the State Agency from the Reportable Event dated 7/5/23 identified that to prevent reoccurrence, Resident #15 would be reminded to lock the wheelchair when stationary. Additionally, the summary from the Reportable Event identified Resident #15 had confirmed thoracic fractures. An interview and RCP review with the MDS Coordinator (RN #1) on 3/4/24 at 12:07 PM identified that the interventions (remind resident to lock the wheelchair when stationary) from the Corrective Action Plan was not added/included in the RCP. She further identified it was the responsibility of the Director of Nursing Services (DNS) to add interventions to the RCP resulting from the Corrective Action Plan, however the MDS Coordinator could also add interventions, as they work together. Subsequent to surveyor's inquiry, the intervention to remind the resident to lock the wheelchair when stationary was added to the RCP. c. A physician's order dated 10/11/23 through 3/5/24 directed that Resident #15 was an assist of 1 for bed mobility, independent with a 4 wheeled walker for transfers, and independent with a 4 wheeled walker for ambulation on the unit with supervision outdoors. The Resident Care Plan (RCP) dated 10/30/23 identified Resident #15 was at risk for falls and that Resident #15 had limited physical mobility. Interventions included a dycem to the wheelchair cushion, call bell within reach, encourage resident to wear nonskid socks over his/her stockings, and that the resident was an assist of 1 for bed mobility, independent with a 4 wheeled walker for transfers, and independent with a 4 wheeled walker for ambulation on the unit with supervision outdoors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was moderately cognitively impaired, was independent with walking and sit to lying, and required supervision or touch assistance with sit to stand. A Reportable Event form dated 12/4/23 at 12:00 PM identified Resident #15 had an unwitnessed fall with reported spine pain after and he/she was sent to the hospital for evaluation. The root cause/conclusion from the Reportable Event investigation identified that the resident must wear rubber sole shoes. A nurse's note dated 12/5/23 at 2:21 AM identified Resident #15 had returned to the facility without any acute injuries or fractures to the thoracic/lumbar spine. An interview and RCP review with the MDS Coordinator (RN #1) on 3/4/24 at 12:07 PM identified that the interventions (the resident must wear rubber sole shoes) from the corrective action to prevent recurrence on the Reportable Event dated 12/4/23 were not added/included in the RCP. She further identified it was the responsibility of the Director of Nursing Services (DNS) to add interventions to the RCP resulting from the Corrective Action Plan, however the MDS Coordinator could also add interventions, as they work together. Subsequent to surveyor's inquiry, the intervention that the resident must wear rubber sole shoes was added to the RCP. Review of the Care Planning policy directed, in part, that a comprehensive RCP is developed within 7 days of completion of the resident assessment (MDS). The RCP is created by Interdisciplinary Team. The resident and family, or legal representative, are encouraged to participate in the development of and revisions to the RCP. RCP meetings will be scheduled at times best for the resident and family.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Governor's Hous	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 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50095

Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 sampled residents reviewed for abuse (Resident #15) the facility failed to complete a nurse's note for the refusal of treatment, and for 1 of 4 sampled residents (Resident #33) reviewed for medication administration, the facility failed to check placement of the gastrostomy tube prior administering medication and feeding. The findings include:

1. Resident #15's diagnoses included dementia, depression, and anxiety disorder.

The Resident Care Plan (RCP) dated 10/30/23 identified that Resident #15 had episodes of urinary incontinence, the potential for alteration in skin related to incontinence, and had decreased communication skills related to hearing loss. Interventions included to provide incontinent care as needed, to toilet the resident upon waking/prior to meals, to use simple direct communication, to verify verbal communication by repeating back to resident, and to ensure hearing aids were working properly.

The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was moderately cognitively impaired, was highly hearing impaired, required partial/moderate assistance with personal hygiene, and required setup or clean up assistance with toileting hygiene.

A Reportable Event form dated 1/8/24 on the 11:00 PM to 7:00 AM shift identified that Resident #15 reported to a family member that he/she had been touched inappropriately overnight and that the facility initiated an investigation.

A nurse's note dated 1/8/24 at 1:44 PM identified that a call had been received from Resident #15's family member regarding concerns of Resident #15's overnight care. The Director of Nursing Services (DNS) had a conversation with the resident and notified the Administrator, Medical Director, Psychiatric Advanced Practice Registered Nurse, and Social Work, as well as the Police Department.

A physician's progress note dated 1/8/24 at 2:45 PM identified that Resident #15 should be evaluated in the emergency room (ER) for a rape kit and Gynecological assessment.

An interview and review of the nurses notes with the DNS on 3/4/24 at 12:42 PM identified that Resident #15's family member had told her that they did not want Resident #15 to go to the ER, however the DNS had not documented the refusal of treatment in a nursing note. Additionally, she had identified she had documented on the Reportable Event form but not in the nurses notes.

Subsequent to surveyor inquiry, a late entry nursing note was added 3/4/24 dated for 1/8/24 and was chronologically inserted in-between the 1/8/24 notes identifying refusal of the ER visit.

2. Resident #33's diagnoses included Parkinson's disease, severe protein calorie malnutrition, and a malignant neoplasm of the head and neck.

The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 was moderately cognitively impaired and required extensive assistance with bed mobility, transfer, eating, and required a feeding tube.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated 2/21/24 identified Resident #33 required a tube feeding related to dysphagia, a swallowing problem, and, at times, refused his/her tube feeding. Interventions included administering tube feeding and water flushes, per physician orders, check for tube placement and gastric contents/residual volume per facility protocol and record, and hold feeding if greater than 500 milliliters (ml) of aspirate (return of gastric content). A physician's order dated 2/28/24 directed Oxycodone 10 milligrams to be given via gastrostomy tube every 4 hours related to chronic pain, may crush tablet and enteral feeding three times a day via bolus tube feeding with [NAME] Farms 1.4 (1) 325 milliliter (ml) carton at 11:00 AM, (1) 325 ml carton at 2:00 PM and (1) 325 ml carton at 5:00 PM four times a day, medications may be administered via gastrostomy tube or by mouth at resident's preference; flush tube with 5 to 10 ml between each medication, Provide 30 ml free water flush before and after each bolus feed. Observation of medication administration with LPN #1 on 3/4/24 at 11:41 AM identified LPN #1 poured the Oxycodone tablet into a medication cup and crushed the medication. LPN #1 then mixed the medication with water. At the bedside, LPN #1 was observed to attach the feeding tube syringe to the gastrostomy tube and instilled the Oxycodone through the gastrostomy tube without the benefit of checking the tube placement prior to administration. LPN #1 indicated that she had checked placement prior to medication and feeding administration but earlier in the morning. LPN #1 was not aware of the facility policy for checking gastrostomy tube placement each time the gastrostomy tube required access. LPN #1 was unable to identify how she would have known if the tube had migrated out of its proper positioning. Review of the medication administration enteral tube policy directed, in part, to check the placement of the gastrostomy tube in accordance with facility policy. (a.) place resident in proper position with head of bed elevated 45 degrees. (b.) insert a small amount of air into the tube with a syringe and listen with a stethoscope for placement. 50177 50179

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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** 48879 50094 50095 50177 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 sampled residents reviewed for abuse (Resident #15), the facility failed to complete an assessment by a Registered Nurse after an allegation of mistreatment and for 1 of 3 sampled resident reviewed for hospitalization (Resident #55), the facility failed to obtain physician orders for multiple hospital transfers and for the only sampled residents (Resident #64) reviewed for death, the facility failed to transcribe Registered Nurse (RN) pronouncement orders before an RN pronouncement was completed. The findings include: 1. Resident #15's diagnoses included dementia, depression, and anxiety disorder. The Resident Care Plan (RCP) dated [DATE] identified that Resident #15 had episodes of urinary incontinence, the potential for alteration in skin related to incontinence, and had decreased communication skills related to hearing loss. Interventions included to provide incontinent care as needed, to toilet the resident upon waking/prior to meals, to use simple direct communication, to verify verbal communication by repeating back to resident, and to ensure hearing aids were working properly. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was moderately cognitively impaired, was highly hearing impaired, required partial/moderate assistance with personal hygiene, and required setup or clean up assistance with toileting hygiene. A Reportable Event form dated [DATE] on the 11:00 PM to 7:00 AM shift identified Resident #15 reported to a family member that he/she had been touched inappropriately overnight and that the facility initiated an investigation. A nurse's note dated [DATE] at 1:44 PM identified that a call had been received from Resident #15's family member regarding concerns of Resident #15's overnight care. The Director of Nursing Services (DNS) had a conversation with Resident #15 and notified the Administrator, Medical Director, Psychiatric Advanced Practice Registered Nurse, and Social Work, as well as the Police Department. A physician's progress note dated [DATE] at 2:45 PM identified that Resident #15 should be evaluated in the emergency room (ER) for a rape kit and Gynecological assessment. An interview and Reportable Event review with the DNS on [DATE] at 12:42 PM identified that Resident #15's family member had refused for him/her to be seen at the ER. Also, an RN assessment after the allegation had not been completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with MD #1 on [DATE] at 3:14 PM identified that he could not perform an assessment on the resident due to cognitive concerns and that he advised for the resident to be evaluated in the ER. An additional interview with the DNS on [DATE] at 9:25 AM identified she would have been responsible for completing the RN assessment after the allegation. She was unable to identify the reason she did not complete an assessment. Review of the Abuse policy directed, in part, that upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record. 2. Resident #55 's diagnoses included chronic obstructive pulmonary disease, heart failure, and respiratory failure. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 was moderately cognitively impaired and required set up assistance for eating, moderate assistance for transfers, and was independent for bed mobility. The Resident Care Plan dated [DATE] identified that Resident #55 was at risk for respiratory distress. Interventions included to monitoring for signs and symptoms of respiratory distress, provide medications per physician's orders, monitor vital signs as ordered, elevate the head of the bed to prevent shortness of breath, and encouraging rest periods as needed. Review of the Hospital Transfer Forms in the clinical record identified that Resident #55 was transferred to the hospital two times on [DATE], and once on [DATE] and [DATE]. Physician's order dated [DATE] through [DATE] failed to reflect any active or discontinued orders directing the staff to transfer Resident #55 to the hospital. Interview and clinical record review with the DNS on [DATE] at 12:52 PM identified the clinical record failed to reflect a physician's order to transfer Resident #55 to the hospital for evaluation on three separate dates: [DATE], [DATE], and [DATE]. The DNS indicated that there should always be a physician's order entered when a resident was transferred to the hospital for evaluation, per the facility policy. She stated it was her expectation that in an emergency, the physician's order to send the resident out to the hospital be entered as soon as possible after the emergency, but not to exceed the same day. Review of the Physician's Orders, Medication, and Treatment Orders policy dated 2014, directed, in part, that verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, and the date and time of the order. Review of the Transfer or Discharge, Emergency policy dated 2012, directed, in part, to notify the resident's attending physician. 3. Resident #64's diagnoses included Hodgkin's lymphoma, pneumonitis, chronic obstructive pulmonary disease, and ischemic cardiomyopathy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #64 was severely cognitively impaired, required partial/moderate assistance for oral hygiene, dependent of toileting hygiene, dependent for showering and upper/lower body dressing. Nursing notes dated [DATE] at 12:41 AM and written by RN #10 identified she observed Resident #64 not breathing at 11:40 PM on [DATE], no heart rate and no pupillary response. Additionally, the nursing note identified she pronounced Resident #64 dead at 11:50 PM on [DATE] and MD #3 was notified. Although a physician progress note dated [DATE] identified the physician confirmed a Do Not Resuscitate/Do Not Intubate/RN may pronounce with Resident #64's family, a review of the clinical record failed to identify a RN pronouncement physician order was written and in place prior to the RN pronouncement of death. Physician orders dated [DATE] directed RN pronouncement orders (obtained after the RN pronouncement of Resident #64's death had occurred). Interview with RN #10 on [DATE] at 9:53 AM identified she would check the paper chart/physician orders for the code status of a resident because it was more reliable than the electronic health record. RN #10 cannot recall if Resident #64 had an RN pronouncement order at the time of pronouncement. Interview with the Director of Nursing (DNS) on [DATE] at 10:00 AM identified that the RN pronouncement order was placed in the electronic health record on [DATE] (after Resident #64 expired), stated that RN #10 called her about not having an RN pronouncement order in place at Resident #64's time of death and then called MD #3, who then directed an order after RN #10 had made the pronouncement of death. Interview with MD #1 on [DATE] at 10:58 AM identified that he would expect an RN pronouncement order to be placed before the pronouncement of a resident's death.

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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 0686 Level of Harm - 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** 48950 Based on observations, review of the clinical record, staff interview, and review of facility documentation for 1 of 3 residents (Resident #39) reviewed for pressure ulcers, the facility failed to ensure off-loading of the heels was implemented to prevent a pressure ulcer. The findings include: Resident #39 was admitted to the facility on [DATE] with diagnosis of cerebral vascular infarction (CVA), pleural effusion, and hemiplegia/hemiparesis. A Discharge Summary from the hospital dated 10/20/23 identified Resident #39's skin was without rashes, ulcerations, or petechiae. An Admission Braden scale dated 10/20/23 identified Resident #39 was at moderate risk for skin breakdown. A Health Status note dated 10/20/23 identified Resident #39's skin was clean, dry, and intact. The Admission Minimum Date Set (MDS) assessment dated [DATE] identified Resident #39 was moderately cognitively impaired and required maximum assistance for eating, was dependent for toileting, transfers, dressing and personal hygiene. Additionally, the MDS identified Resident #39 was physically impaired on one side, required moderate assistance to roll from one side to the other, was at risk for developing a pressure ulcer and did not have a pressure ulcer at the time of the MDS assessment. Review of the Resident Care Plan failed to identify a care plan regarding Resident #39 being at risk for skin breakdown or interventions that included off-loading of his/her heels. A facility Accident and Incident report dated 11/3/23 identified Resident #39 was observed with a hematoma (bruise) to the left heel that measured 5.0 centimeters (cm) round. A physician's note from the wound doctor dated 11/7/23 identified the wound to the left heel was a deep tissue injury (DTI) measuring 4.0 cm in length by 4.0 cm in width with an area of 16 square centimeters. Physician orders (subsequent to Resident #39 developing a DTI) dated 11/8/23 directed to provide a heel offloading cushion under Resident #39's bilateral lower extremities while in bed, always keep left heel off the bed, and apply skin prep to the left heel every shift. The Resident Care Plan was updated on 11/8/23 identifying a pressure injury related to the left heel with interventions that included to offload Resident #39's heels while in bed, turn and reposition per nursing standards of care/per policy, and check skin as least weekly on a scheduled bath day (which was Thursday). On 3/4/24 at 11:15 AM, observation of Resident #39 with LPN #1 identified Resident #39's heels were off loaded with a pillow. Additionally, a round DTI wound measuring 2.5 cm by 2.5 cm was observed to Resident #39's left heel. Additionally, no drainage or odor was noted, and the area was dry. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview and review of the clinical record with RN #3 and RN #5 on 3/4/24 at 3:27 PM failed to identify Resident #39's heels were offloaded prior to a DTI developing on 11/3/23. Additionally, RN #3 and RN #5 identified a resident with a moderate risk for skin break down should have a care plan upon admission for potential for alterations in skin integrity which would include turning and repositioning, a pressure relieving mattress and skin checks weekly. Interview RN# 1 on 3/5/24 at 9:16 AM identified that a care plan for potential for alteration in skin integrity would include off-loading heel, repositioning, facility skin protocol, and a pressure reducing mattress. RN #1 stated it was her responsibility to initiate a care plan for pressure ulcer prevention. Interview with the Wound MD on 3/5/24 at 11:55 AM indicated that if Resident #39 had interventions to offload the heels implemented upon admission the resident would not have developed the DTI. Interview with NA #2 on 3/5/24 at 2:04 PM noted she routinely cared for Resident #39 who required assistance to offload his/her heels, reposition and turn her/himself. NA #2 further identified Resident #39 could not self-elevate his/her bilateral extremities. The facility policy for Care Plan states the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Care plans are maintained in the resident's clinical record and serve as a guide by which care is delivered and steered. The facility policy for Skin Assessment and Pressure Ulcer Prevention identifies A comprehensive skin assessment is done on every resident upon admission and the weekly. The Nursing Assistant caring for the resident monitors the skin daily and reports any changes to the licensed nurse. It is the policy of this facility that residents who are admitted without a pressure ulcer does not develop a pressure ulcer unless clinically unavoidable.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48950

Based on staff interviews, facility documentation, observations, and review of the clinical record for 1 of 1 sampled residents (Resident #39) reviewed for splints, the facility failed to ensure that a hip abduction splint was applied daily as directed by the physician. The findings included:

Resident #39 was admitted to the facility on [DATE] with a diagnosis of cerebral vascular infarction (CVA), pleural effusion, and lung cancer.

A Quarterly Minimum Date Set (MDS) assessment dated [DATE] identified Resident #39 was moderately cognitively impaired and required set up for eating, moderate assistance for toileting, transfers, and dressing. The MDS further identified Resident #39 required supervision assistance for personal hygiene and was physically impaired on one side.

A physician order dated 11/7/23 directed to don (put on) a hip abduction splint when up in the wheelchair, doff (take off) while in bed

A Resident Care Plan dated 11/7/23 identified Resident #39 had reduced positioning when sitting in the wheelchair due to cerebral vascular accident. Interventions included to don a hip abduction splint while in the wheelchair and doff when resident was in bed. The goal was for Resident #39 to be appropriately positioned when sitting in the wheelchair for proper lower extremity positioning utilizing hip abduction splint and elevating leg rests through the next review date.

Review of the treatment admission record (TAR) from 11/7/23 through 2/28/24 failed to identify the hip abduction splint was included.

On 2/28/24 at 1:00 PM, observation of Resident #39 with LPN #1 noted him/her to be in a wheelchair in the staff dining area, without the benefit of a hip abduction splint in place.

On 2/28/24 at 2:10 PM, an interview and review of the TAR dated 2/2824 with LPN #1 failed to identify the hip abduction splint was included. LPN #1 was unsure of the reason the hip abduction splint was not applied to Resident #39, and could not see any record of it being included on the TAR.

Interview on 3/4/24 at 11:15 AM with the Rehab Director (PT) #1 stated the travel Physical Therapist (who was no longer with the facility) placed the order and put order in the computer system incorrectly and that was the reason the hip abduction splint never was included on the TAR. Resident #39 needed the splint for positioning while in the wheelchair as he/she sat to one side which was called wind swept, the hip abduction splint was to keep Resident #39 legs apart. She stated that Resident #39 should have been added to the splint list and training should have been provided for the Nurses Aides and the nurses.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy Preferred Therapy Solutions identified splints, either custom made or prefabricated, are used to provide proper body support, prevent unwanted motion. Contracture management or reduction, pain management, and to facilitate motor activity. Therapist coordinates with the interdisciplinary team to determine splinting needs and to monitor appropriate use and fit on a regular basis. Subsequent to surveyor inquiry, the Director of Rehab charted a functional area of change dated 2/28/24 stating the Resident #39 refused to utilize the hip abduction splint and screened Resident #39 on 3/6/24.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on observations, review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #55) reviewed for oxygen therapy, the facility failed to obtain a physician's order for oxygen administration. The findings include: Resident #55's diagnoses included respiratory failure with hypoxia, pneumonia, and Chronic Obstructive Pulmonary Disease (COPD). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 was cognitively intact and required moderate assistance for bed mobility and personal hygiene, and required maximum assistance for transfers. Additionally, the MDS identified Resident #55 utilized oxygen therapy. The Resident Care Plan dated 2/28/24 identified Resident #55 had COPD and required supplemental oxygen. Interventions included oxygen administration as ordered by the physician, oxygen saturation as ordered and per policy, monitoring for signs and symptoms of respiratory distress, and encouraging rest periods as needed. Observations on 2/28/24 at 11:55 AM, on 2/29/24 at 11:55 AM, and on 3/1/24 at 10:10 AM identified Resident #55 utilizing oxygen at 2.0 liters per minute (lpm) via a nasal cannula. Interview, observation, and clinical record review with LPN #6 on 3/1/24 at 10:18 AM identified that Resident #55 was utilizing oxygen via a nasal cannula at 2.0 lpm. LPN #6 was not able to locate any active or discontinued oxygen physician orders, but stated Resident #55 had been on oxygen for at least a few weeks. She reported that Resident #55 went out to the Pulmonary physician recently and maybe the order was never transcribed, but she indicated that there should be an active physician's order for the resident to be utilizing oxygen. Interview with RN #2 on 3/1/24 at 10:29 AM identified that she was not able to locate either an active or discontinued oxygen order for Resident #55. She indicated she also checked with the former Nursing Supervisor, who was also not able to locate an order, but that she would obtain a physician's order and enter it into the clinical record. Subsequent to surveyor interview, a physician's order was obtained on 3/1/24 at 11:15 AM directing oxygen at 2.0 lpm via nasal cannula to maintain an oxygen saturation greater than 91% as needed. The facility policy regarding the Use of Oxygen: Nasal Cannula policy dated 1/1/2019 directed, in part, that oxygen is used only once an order is verified.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 5 residents (Resident #7 and Resident #43) reviewed for unnecessary medication, the facility failed respond to pharmacy recommendations related to an as needed (PRN) psychotropic medication. The findings include: 1. Resident #7's diagnoses included Alzheimer's disease, anxiety disorder and Type 2 diabetes. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 was moderately cognitively impaired, required practical assistance with shower transfer and toileting hygiene and maximal assistance with showering. The Resident Care Plan dated 11/10/23 identified Resident #7 had episodes being resistive to care- refused to shower and refused to change clothes. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness. A physician's order dated 11/13/23 directed to provide Ativan (Lorazepam) 0.5 milligrams (mg), give 1 tablet by mouth every 24 hours as needed for anxiety/agitation prior to showers (administer 45 minutes prior to shower). However, the physician order failed to indicate a stop date. Nursing Notes dated 11/13/23, 11/24/23, 12/14/23 and 1/26/24 identified Resident #7 was administered Ativan (Lorazepam)0.5 mg prior to a shower for anxiety. Interview with Pharmacy consultant on 3/5/23 at 10:24 AM indicated that he had provided recommendations for Resident #7 on 1/8/24 and 2/8/24 that indicated that PRN for psychotropic drugs are limited to 14 days, and further assessment by the prescribing physician was required if a PRN should be extended. Interview with the DNS on 3/5/24 at 12:10 PM indicated that she was unable to locate the signed acknowledged pharmacy recommendation for Resident # 7 from the November 2023 to March 2024 time frame. Interview with the DNS on 3/5/24 at 1:00 PM indicated that once pharmacy consults/recommendation were sent to the facility, consults are placed in the Medical Director's box and reviewed. The DNS indicated she and the Nursing Supervisors were responsible for putting the approved order in the medical records. The DNS was unable to explain the reason this was not done. Interview with the DNS on 3/5/24 at 2:17 PM indicated that she did not see a psychiatrist note from 12/18/23, which directed Ativan 0,5 mg PRN for 14 days. Subsequent to surveyor inquiry Ativan 0.5 mg PRN was discontinued on 3/5/24. 2. Resident #43's diagnoses included dementia, depressive episodes, and history of fractures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024
NAME OF PROVIDER OR SUPPLIER: Ark Healthcare & Rehabilitation at Governor's Hous		STREET ADDRESS, CITY, STATE, ZIP CODE: 36 Firetown Rd Simsbury, CT 06070	

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 was moderately cognitively impaired, was not identified to have behaviors, and required extensive one-person physical assistance with personal hygiene. Additionally, the MDS identified Resident #43 received an antidepressant medication. The Resident Care Plan (RCP) dated 2/17/22 identified Resident #43 had impaired cognitive function and thought processes related to dementia, and a mood problem related to admission. Interventions included to administer medications as ordered, monitor/document side effects and effectiveness, and behavioral health consults, including psychiatry, as needed. A physician's order dated 11/3/21 through 3/5/24 directed to administer Trazodone (medication used for depression) 25 mg every 8 hours PRN for agitation but failed to include a stop date of 14 days. Medication Administration Record dated 12/17/21, 12/26/21, 1/1/22, 1/2/22, 1/9/22, 1/15/22, 1/17/22, and 1/18/22 identified Resident #43 received Trazodone 25 mg for agitation. Although PRN Trazodone was renewed monthly by the physician, the resident had not received subsequent PRN doses. b. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 had a short/long term memory problem, was identified to have verbal behavioral symptoms occurring 1 to 3 days, and other behavioral symptoms occurring 4 to 6 days. Additionally, the MDS identified Resident #43 required partial/moderate assistance with toileting hygiene and upper/lower body dressing and that the resident received an antidepressant medication. The Resident Care Plan (RCP) dated 11/11/22 identified that Resident #43 used an antidepressant medication related to depression and psychotropic medications related to paranoia. Interventions included to administer medications as ordered, educate about the risks, monitor/document regarding adverse reactions, and to consult with the pharmacy/physician to consider a dosage reduction when clinically appropriate at least quarterly. A physician's order dated 10/14/22 through 2/14/24 directed to administer Ativan (medication used for anxiety) 0.5 mg every 4 hours PRN for anxiety but failed to include a stop date of 14 days. A physician's order dated 2/14/24 through 3/5/24 directed to administer Ativan 0.5 mg every 6 hours (decreased frequency from previous order of every 4 hours) PRN for anxiety or agitation. Do not give if resident is sleepy, lethargic, or sedated. Medication Administration Record dated 6/17/23, 6/21/23, 6/23/23, 6/26/23, 7/9/23, 7/29/23, and 7/30/23 identified Resident #43 received Ativan 0.5 mg for anxiety. Although PRN Ativan was renewed monthly by the physician, the resident had not received subsequent PRN doses. (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Consultant Pharmacist Recommendations dated 2/8/22 identified that the Centers for Medicare and Medicaid Services guidelines will limit PRN psychotropic orders to 14 days maximum use without a reassessment. Recommendations included for the physician to assess continued need for PRN Trazodone or add a specific stop date to the order. The same recommendation was identified subsequently in the 5/6/22 and 8/12/22 reports. The 8/13/23 report included the same recommendation for PRN Ativan, as well as PRN Trazodone. All Pharmacy reports received failed to identify the physician responded to pharmacy recommendations. Additionally, pharmacy medication review failed to identify an open-ended PRN order for Trazodone and/or Ativan on 3/8/22, 4/7/22, 6/10/22, 7/14/22, 9/7/22, 11/7/22, 12/8/22, 1/4/23, 2/7/23, 3/6/23, 4/14/23, 5/9/23, 7/14/23, 9/20/23, 10/20/23, 11/10/23, 12/9/23, 1/8/24, and 2/9/24 despite the resident being prescribed PRN Tradozone and/or Ativan. An interview with MD #1 on 3/4/24 at 3:16 PM identified that he was aware that psychotropic PRN medications should only be ordered for 14 days and could not identify the reason he did not include the 14 days stop date, but Resident #43 had been on psychotropic PRN medications for a long time. An interview with the Pharmacy Consultant on 3/5/24 at 10:10 AM identified that the duration of PRN psychotropic medications had been addressed in past reports. An interview with the Director of Nursing Services (DNS) on 3/5/24 at 1:00 PM identified that she did not have a reason why the pharmacy reports and recommendations were not responded to by the physician. An additional interview with the Pharmacy Consultant on 3/6/24 at 12:05 PM identified that a pharmacy progress note stating no irregularities was generated when there is no physician recommendation report. 50177

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 5 residents (Resident # 7 and #43) reviewed for unnecessary medication, the facility failed to order as needed (PRN) psychotropic medications for only 14 days. The findings include: 1. Resident #7's diagnoses included Alzheimer's disease, anxiety disorder and Type 2 diabetes. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 was moderately cognitively impaired and required practical assistance with shower transfer and toileting hygiene and maximal assistance with showering. The Resident Care Plan dated 11/10/23 identified Resident #7 had episodes of resistive to care- refused to shower, and refused to change clothes. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness. A physician's order dated 11/13/23 directed to provide Ativan (Lorazepam) 0.5 milligrams (mg), give 1 tablet by mouth every 24 hours as needed for anxiety/agitation prior to showers (administer 45 minutes prior to shower). However, but failed to indicate a stop date. Nursing notes dated 11/13/23, 11/24/23, 12/14/23 and 1/26/24 identified Resident #7 was administered Ativan (Lorazepam) prior to his/her shower for anxiety. Interview with the Pharmacy Consultant on 3/5/23 at 10:24 AM indicated that he had provided recommendations on 1/8/24 and 2/8/24 that indicated that PRN usage for psychotropic drugs were limited to 14 days, and further assessment by the prescribing physician was required if a PRN should be extended. Interview with the DNS on 3/5/24 at 12:10 PM indicated that she was unable to locate the signed acknowledged pharmacy recommendation for Resident #7 from the November 2023 to March 2024 time frame. Interview with the DNS on 3/5/24 at 1:00 PM indicated that once pharmacy consults/recommendations were sent to the facility, the recommendations were placed in the Medical Director's box and reviewed. The DNS indicated she and the Nursing Supervisors were responsible for putting the approved order in the medical records. The DNS was unable to explain the reason this was not done. Interview with the DNS on 3/5/24 at 2:17 PM indicated that she did not see the Psychiatrist note from 12/18/23, which directed Ativan PRN for 14 days. Subsequent to surveyor inquiry, Ativan 0.5 mg PRN was discontinued on 3/5/24. 2. Resident #43's diagnoses included dementia, depressive episodes, and history of fractures. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 was moderately cognitively impaired, was not identified to have behaviors, and required extensive one-person physical assistance with personal hygiene. Additionally, the MDS identified Resident #43 received an antidepressant medication. The Resident Care Plan (RCP) dated 2/17/22 identified Resident #43 had impaired cognitive function and thought processes related to dementia, and a mood problem related to admission. Interventions included to administer medications as ordered, monitor/document side effects and effectiveness, and behavioral health consults, including psychiatry, as needed. A physician's order dated 11/3/21 through 3/5/24 directed to administer Trazodone (medication used for depression) 25 milligrams (mg) every 8 hours PRN for agitation but failed to include a stop date of 14 days. Medication Administration Record dated 12/17/21, 12/26/21, 1/1/22, 1/2/22, 1/9/22, 1/15/22, 1/17/22, and 1/18/22 identified Resident #43 received Trazodone 25 mg for agitation. Although PRN Trazodone was renewed monthly by the physician, the resident had not received subsequent PRN doses. b. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 had a short/long term memory problem, was identified to have verbal behavioral symptoms occurring 1 to 3 days, and other behavioral symptoms occurring 4 to 6 days. Additionally, the MDS identified Resident #43 required partial/moderate assistance with toileting hygiene and upper/lower body dressing and that the resident received an antidepressant medication. The Resident Care Plan (RCP) dated 11/11/22 identified that Resident #43 used an antidepressant medication related to depression and psychotropic medications related to paranoia. Interventions included to administer medications as ordered, educate about the risks, monitor/document regarding adverse reactions, and to consult with the pharmacy/physician to consider a dosage reduction when clinically appropriate at least quarterly. A physician's order dated 10/14/22 through 2/14/24 directed to administer Ativan (medication used for anxiety) 0.5 mg every 4 hours PRN for anxiety but failed to include a stop date of 14 days. A physician's order dated 2/14/24 through 3/5/24 directed to administer Ativan 0.5 mg every 6 hours (decreased frequency from previous order of every 4 hours) PRN for anxiety or agitation. Do not give if resident is sleepy, lethargic, or sedated. Medication Administration Record dated 6/17/23, 6/21/23, 6/23/23, 6/26/23, 7/9/23, 7/29/23, and 7/30/23 identified Resident #43 received Ativan 0.5 mg for anxiety. Although PRN Ativan was renewed monthly, the resident had not received subsequent PRN doses. An interview with MD #1 on 3/4/24 at 3:16 PM identified that he was aware that psychotropic PRN medications should only be ordered for 14 days and could not identify the reason he did not include the 14 days stop date, but Resident #43 had been on psychotropic PRN medications for a long time. An interview with the Pharmacy Consultant on 3/5/24 at 10:10 AM identified that the duration of PRN psychotropic medications had been addressed in past reports. (continued on next page)

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent to surveyor inquiry, both Trazodone and Ativan PRN medications were discontinued on 3/5/24. Review of the Psychotropic Medication PRN Usage policy directed, in part, that medication renewal is required every 14 days. To continue use, a new order for the PRN medication may be written if the prescribing practitioner directly examines and assesses the resident and documents the rationale for continuing use, which should include benefits of use for the resident. 50177

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50250 Based on staff interview and review of Payroll Based Journal (PBJ) submissions for Quarter 3 in 2023 (April 1, 2023 through June 30, 2023), the facility failed to ensure the data was accurate and did not reflect excessively low weekend staffing. The findings include: PBJ submissions for Quarter 3 of 2023 (April 1, 2023 through June 30, 2023) identified excessively low weekend staffing. On 3/6/24 at 11:12 AM, interview with the Administrator identified the facility provides both payroll hours worked for their employees and agency employees to a contracted company who then submits the data to CMS. She further identified that staffing levels were not low during Quarter 3 in 2023, the long term care facility company identified low staffing pattern submissions, and would review the contracted company reporting procedures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48950 Based on the staff interviews, facility documentation, and review of the facility policies, the facility failed to ensure that Infection Prevention Control Program standards (IPCP) policies and procedures are reviewed annually by the Administrator, Medical Director, and the Director of Nursing and that the facility maintained an updated list of residents with Multidrug Resistant Organism. (MDRO) The findings included: On 3/1/24 at 11:07 AM, review of the Infection Prevention policies/procedure manual with RN #6 (the Infection Preventionist) and RN #7 (the previous Infection Preventionist) failed to identify the policies had been reviewed and signed by the Administrator, Medical Director, and Director of Nursing annually. Additionally, the signature page was blank, with no signatures present and both RNs stated that they were unaware that the policies needed to be signed on an annual bases. The MDRO (Multidrug Resistant Organisms) list was last updated on 4/14/23 with some of those residents having been discharged or no longer in the same rooms as identified on the MDRO list. RN #7 stated on 3/1/24 the Director of Admissions was aware of which residents were on the MDRO list and she was the one who had a current list. Interview on 3/1/24 at 2:17 PM with the Director of Admissions identified she had no knowledge of which residents were on the MDRO list and denied having a current or historical list of residents that had a MDRO. Subsequent to surveyor inquiry, the facility completed an updated MDRO log on 3/4/24.

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F 0881 Level of Harm - Potential for minimal harm Residents Affected - Many	Implement a program that monitors antibiotic use. 48950 Based on staff interviews, facility documentation and review of antibiotic stewardship program, the facility failed to ensure that the policies were reviewed on an annual basis and that data was kept and analyzed according to federal regulations. The findings included: On 3/1/24 at 11:07 AM, review of the facility infection control policy and procedure manual with RN #6 (the Infection Preventionist) and RN #7 (the previous facility Infection Preventionist) failed to identify that facility staff had reviewed the infection control manual on an annual basis. On 3/1/24 at 11:15 AM, review of the antibiotic stewardship program with RN #6 and RN #7 failed to identify that the facility was calculating monthly antibiotic use percentages and failed to identify that percentages were used and reviewed with the Quality Assurance program on a quarterly basis. Further interview with RN #6 and RN #7 on 3/1/24 at 11:15 AM identified that they were unaware that the facility was required to keep percentages of antibiotic use, infections that required antibiotic use, intravenous policies and to have the infection control policies and intravenous policies and procedures signed and reviewed by Medical Director, Director of Nursing, and the Administrator on an annual basis. RN #6 was unaware antibiotic use needed to be calculated to identify percentages monthly and be reviewed with quality assurance.

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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** 48950 Based on staff interviews, facility documentation, and review of the clinical record for 2 of 5 residents (Resident #26 and Resident #39) reviewed for immunizations, the facility failed to ensure that Resident #26 was provided with the Influenza vaccine after receiving consent. Also, the facility failed to ensure that Resident #39 or the resident representative was educated and given the opportunity to consent or decline the Pneumonia vaccination upon admission and subsequent to admission to the facility. The findings include: 1. Resident #26 was admitted to the facility on [DATE] with a diagnosis of heart disease, dementia, and diabetes. Interview and review of the facility immunization tracking with RN #6 (Infection Control Nurse) and RN #7 (the previous Infection Control Nurse) on 3/1/24 at 11:07 AM identified that RN #6 received consent upon admission for Resident #26 to receive the Influenza immunization for the 2023/2024 season. Resident #26 was ill and had Covid-19 on 10/4/23 and that RN #6 never provided the immunization once Resident #26 recovered from Covid 19. Resident #26 was hospitalized for Influenza on 2/23/24 and had since returned to the facility. 2. Resident #39 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (CVA), pleural effusion, and lung cancer. On 3/1/24 at 11:15 AM, interview and review of Resident #39's immunization record with RN #6 failed to provide documentation that Resident #39 was offered to receive/decline or provide proof of a previous Pneumonia vaccination. Interview on 3/1/24 at 11:15 AM with RN #7 indicated when someone was on the short term rehab unit, the facility does not offer pneumonia vaccines and the residents are directed by the Medical Director to go to their primary care physician for the Pneumonia vaccine. Facility Policy for Influenza Vaccines states that the vaccine shall be offered to residents between October 1st and March 31st. The Infection Preventionist will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff. Facility Policy for Influenza, Prevention and Control of Seasonal states that the Infection Preventionist will promote and administer seasonal influenza vaccines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Policy for Pneumococcal Vaccine states prior to or upon admission, residents will be assessed for the eligibility to receive the pneumococcal vaccines series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessment of the pneumococcal vaccine status will be conducted with in 5 working days of the resident's admission if not conducted prior to admission. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effect of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. Residents/representative have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of refusal of the pneumococcal vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on staff interviews, facility documentation, and review of the clinical record for 2 of 5 sampled residents (Resident #11 and Resident #59) reviewed for immunizations, the facility failed to ensure upon admission, the residents or resident representative was educated and given the opportunity to consent or decline the Covid-19 vaccine. The findings included: 1. Resident #11 was admitted to the facility on [DATE] with diagnosis of an autoimmune disease, sepsis, and calculus of the kidney. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 was moderately cognitively impaired and dependent for toileting and dressing, set up for eating and substantial assist for personal hygiene. 2. Resident #59 was admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease, sepsis, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 moderately cognitively impaired and was dependent for dressing, personal hygiene, toileting, and maximum assist for eating and transfers. Interview and review of the facility immunization tracking with Registered Nurse (RN) #6 (the Infection Preventionist) and RN #7 (the previous facility Infection Preventionist) on 3/1/24 at 11:07 AM failed to identify Resident #11 and Resident #59 was offered the Covid-19 vaccine on and since admission. Additionally, there was not a record of Resident #11 or Resident #39's representative being offered education or an opportunity to receive or decline the Covid-19 vaccination on their behalf. The facility was also unable to provide documentation that Resident #11 or Resident #59 had received the Covid-19 immunization in the past/prior to admission. Additionally, RN #6 stated that she did not offer the Covid-19 vaccination to Resident #11, Resident #59 or their resident representatives on their behalf. The Facility Covid Vaccination of Resident policy states all residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident is already vaccinated and that all new residents shall be assessed for current vaccination status upon admission. If the vaccines are refused, the refusal shall be documented in the resident's medical record. Subsequent to surveyor inquiry, the facility began completing immunization records for residents who received the Influenza, Pneumococcal, and Covid-19 vaccination.

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 19953 Based on review of facility documentation, review of facility policy and interviews 3 of 5 employee files reviewed (Licensed Practical Nurse (LPN) #4, LPN #5 and Registered Nurse (RN) #4), the facility failed to ensure that the required employee training's/inservices were completed. The findings include: 1. LPN #4's date of hire was 12/12/23. Review of the facility time-card documentation for LPN #4 identified that she had worked in the facility between 12/12/23 through 2/2/24. 2. LPN #5's date of hire was 11/15/23. Review of facility time-card documentation for LPN #5 identified that she had worked in the facility between 11/15/23 through 2/24/24. 3. RN #4's date of hire was 9/29/23. Review of facility time-card documentation for RN #4 identified that she had worked in the facility between 10/9/23 through 2/18/24. Review of employee files for LPN #4, LPN #5, and RN #4, failed to identify that new employee orientation training/inservices were completed and in the files. Additionally, the employee files failed to identify that documentation of Abuse/Neglect/Exploitation, Dementia, Infection Control, Communication and Behavioral Health training's were completed and in the files. Interview and record review with the facility Administrator on 3/6/24 at 12:00 PM identified that although the required training's should have been completed upon hire, she was unable to provide documentation that the required training's had been completed for LPN #4, LPN #5 and RN #4. The Administrator further indicated that she did not know the reason the required training's were not completed and that the person responsible for conducting the training had resigned. Facility policy regarding Orientation Program for Newly Hired Employees, Transfers, Volunteers, directed that all newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment.

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Governor's Hous	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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50250 Based on review of facility documentation, employee files, review of facility policy and interviews 1 of 2 Nurse Aide (NA) employee files reviewed (NA #4), the facility failed to ensure that the required employee training/inservices were completed. The findings include: NA #4's date of hire was 9/28/23. Review of the facility time-card documentation for NA #4 identified that she had worked in the facility between 9/28/23 to present. Review of the employee file for NA #4 failed to identify that any inservicing had been provided (Abuse/Neglect/Exploitation, Dementia, Infection Control, Communication and Behavioral Health) and included in the files from the date of hire until present. Interview and record review with the facility Administrator on 3/6/24 at 12:00 PM identified that although the required training/inservices should have been completed upon hire, she was unable to provide documentation that the required inservices had been completed for NA #4. The Administrator further indicated that she did not know the reason the required inservices were not completed and that the person responsible for conducting the training/inservices had resigned. Facility policy regarding Orientation Program for Newly Hired Employees, Transfers, Volunteers, directed that all newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment.