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	12/30/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and interviews for one sample resident (Resident #70) who experienced a significant change in condition, the facility failed to notify the physician and/or family of the significant change of condition. The findings include:Resident #70 had diagnoses that included protein malnutrition, chronic kidney disease, benign neoplasm of meninges, and dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #70 had moderate cognitive impairment, and required extensive assistance with bed mobility, toileting, hygiene, transfers, and ambulation. The Resident Care Plan (RCP) dated 2/19/25 identified Resident #70 had a nutritional problem or potential nutritional problem related to kidney disease, neoplasm of meninges and dementia. Care plan interventions directed to monitor, record, and report to the physician signs and symptoms of malnutrition, evaluate and make diet changes as recommended, obtain and monitor laboratory or diagnostic tests as needed, and provide and serve diet as ordered.The nurse's note dated 3/22/25 at 12:01 AM identified Resident #70 was alert, verbal, had an episode of vomiting which consisted of good amount of a black substance. In addition, the note indicated that the supervisor was notified of the situation.Review of nurses' notes from 3/22/25 through 3/23/25 failed to identify that the physician and/or family were notified of Resident #70's episode of vomiting.The APRN's progress note dated 3/24/25 at 11:45 AM identified Resident #70 was seen related to reports of vomiting over the weekend with dark emesis. The resident denied any gastro-intestinal discomfort, pain and/or tenderness. Resident #70 experienced decreased appetite on the day of vomiting, but his/her appetite had resumed after the episode of vomiting and had not complained of any further gastro-intestinal symptoms.Interview with the DNS on 12/24/25 at 9:00 AM identified that the physician and family member should be notified immediately when a resident has a significant change in condition. In addition, the nurses' notes should indicate whether the physician and the family member were notified. She further identified that black emesis should be an immediate notification to the physician and responsible party. She further identified that she could not verify whether the physician and responsible party were notified because there is not a nurse's note indicating that they were notified.Interview with APRN #1 on 12/29/25 at 10:40 AM identified that the physician and/or APRN would be notified immediately when a resident has a significant change of condition. Although she was not the APRN at the time when Resident #70 had an episode of black emesis, she would expect the nursing staff to notify the physician immediately because black emesis could be a sign of bleeding in the intestinal organ. The Change in Resident Condition, Family, and/or Physician Notification policy identified that all significant changes in a resident's condition will be reported to the physician and family. In addition, the policy also indicated that a registered nurse assessment would be conducted, and the assessment documented, as well as documentation that the physician and the family had been notified.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075338	A. Building B. Wing	12/30/2025

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

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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** Based on review of clinical records, review of facility documentation, review of facility policy/procedures and interviews one sampled record (Resident #70) review for significant change, the facility failed to ensure a registered nurse assessed the resident after a significant change of condition and for one sampled resident (Resident #58) reviewed for pain, the facility failed to ensure a medication was administered according to the physician's order, and for one of two residents (Resident #64) reviewed for pain management, the facility failed to ensure physician orders were obtained timely when a medication was unavailable. The findings include: Resident #70 had diagnoses that included protein malnutrition, chronic kidney disease, benign neoplasm of meninges, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #70 had moderate cognitive impairment, and required extensive assistance with bed mobility, toileting, hygiene, transfers, and ambulation. The Resident Care Plan (RCP) dated 2/19/25 identified Resident #70 had a nutritional problem or potential nutritional problem related to kidney disease, neoplasm of meninges and dementia. Care plan interventions directed to monitor, record, and report to the physician signs and symptoms of malnutrition, evaluate and make diet changes as recommended, obtain and monitor laboratory or diagnostic tests as needed, and provide and serve diet as ordered. The nurse's note dated 3/22/25 at 12:01 AM identified Resident #70 was alert, verbal, had an episode of vomiting which consisted of good amount of a black substance. In addition, the note indicated that the supervisor was notified of the situation. Review of nurses' notes from 3/22/25 through 3/23/25 failed to identify that the physician and/or family were notified of Resident #70's episode of vomiting. The APRN's progress note dated 3/24/25 at 11:45 AM identified Resident #70 was seen related to reports of vomiting over the weekend with dark emesis. The resident denied any gastro-intestinal discomfort, pain and/or tenderness. Resident #70 experienced decreased appetite on the day of vomiting, but his/her appetite had resumed after the episode of vomiting and had not complained of any further gastro-intestinal symptoms. Interview with the DNS on 12/24/25 at 9:00 AM identified that the registered nurse is responsible for comprehensively assessing the resident after a significant change in condition. She identified that the assessment should be documented in the nursing progress notes and/or Situational, Background, Assessment, and Response (SBAR) would be created to identify that resident had a significant change in condition. She identified that Resident #70 had an episode of black emesis which required a comprehensive assessment from a registered nurse that should include an abdominal assessment, bowel sounds, vital sign, and reviewing the resident bowel regimen. She further identified that the resident was not assessed after a significant change in condition because she could not find the assessment in the nursing progress notes nor was a SBAR created after a significant change in condition. The facility Change in Resident Condition, Family, and/or Physician Notification policy identified that (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 Ho	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all significant changes in resident's condition will be reported to the physician and family. In addition, the policy also identified that a registered nurse assessment would be conducted, and the nurse would document that the assessment was completed, the physician, and the family have been notified of the change in condition. 2. Resident #58's diagnoses included Parkinson's, malignant neoplasm of endometrium, and occipital neuralgia. The admission MDS assessment dated [DATE] identified Resident #58 was cognitively intact, had no behaviors, required partial/moderate assistance with bed mobility, transfers, substantial maximal assistance with dressing, and supervision with personal hygiene. The assessment further identified the resident utilized a walker and a wheelchair for mobility. The care plan dated 11/13/25 identified Resident #58 was at risk for pain/discomfort related to endometrial cancer with interventions that included medication as ordered, determine level of pain using pain scale, anticipate the needs for pain relief and respond promptly. Physician orders dated 11/19/25 directed Pregabalin (Lyrica, used to treat nerve pain) oral capsule 25 milligrams (mg) capsule give two capsules orally (50 mg dose) at bedtime for peripheral neuropathy. Review of pharmacy control drugs dispensed identified twenty capsules of pregabalin 25 mg were dispensed from the pharmacy on 12/5/25 for Resident #58. Review of the MAR (Medication Administration Record) for December 2025 identified the medication was administered on 12/20/25 (signed by the nurse as administered). Interview on 12/22/25 at 9:55AM with Resident #58 identified he/she did not receive the full ordered dose of Pregabalin 50 mg on 12/20/25 as the medication was unavailable in the full ordered dose of 50 mg only 25 mg was available. This helps to treat pain and help him/her sleep. Resident #58 identified the facility frequently runs out of medication especially the Pregabalin and that on 12/20/25 was the most recent occurrence. Interview on 12/23/25 at 12:04 PM with Pharmacist #1 identified no refill request was entered on 12/20/25 when the resident was out of the medication until 12/22/25 when a 10-day supply was ordered. The pharmacy identified that it was not them who would only send a 10-day supply, it was the way in which the provider was ordering it from the facility. Pharmacist #1 further identified that the side effect from the resident not receiving the full dose could be the resident having pain. Interview on 12/23/25 at 12:49PM with LPN #7 identified she was the LPN working on 12/20/25 on the 3-11 shift when the ordered dose of Pregabalin 50 mg was due to be administered. LPN #7 indicated that there was one capsule of Pregabalin 25 mg available in Resident #58's blister pack to be administered. LPN #7 identified she went to look for the RN Supervisor to attempt to get another 25 mg dose of Pregabalin from the Pixus (emergency supply). LPN #7 could not locate the supervisor, and the resident really wanted their medication, so she gave Resident #58 the one available and continued to look for the RN Supervisor. LPN #7 found the RN Supervisor, and they went to attempt to retrieve the medication from the Pixus. LPN #7 identified there was only Pregabalin 50 mg available and due to the fact, the order was for 50 mg and 25 mg was already administered the medication was not administered. LPN #7 indicated the RN Supervisor asked her to go back to Resident #58 and see if (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 Ho	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she was ok with the 25 mg dose. LPN #7 informed Resident #58 that the medication was not available, and Resident #58 indicated it helped a little bit but did not help completely as he/she used to get a 300 mg dose a while back. LPN #7 indicated she did not contact any provider about a one-time order for the 25 mg dose or a one-time order to administer a 75 mg dose, she was agency and was told to just contact the supervisor with anything out of the ordinary. Review of the orders and progress notes for 12/20/25 failed to indicate any contact with the provider regarding the discrepancy and no new orders were obtained for this date. Interview with the RN Supervisor was attempted on 12/23/25 and 12/30/25, and the facility was requested to get in touch with the RN supervisor to contact the surveyor however no contact was made by the RN supervisor with the surveyor. Interview on 12/30/25 at 12:10 PM with the ADNS identified initially the APRN who ordered the medication only ordered one dose and it shouldn't have been ordered that way. Since then, it has been ordered for a 10 day supply each time it has been ordered, however the ADNS was unsure if that was the way the prescriber ordered it or if that was the way in which the insurance covered it due to the fact, she was a short-term resident. The ADNS identified that she was aware that there had been an issue with the order running out as it was ordered as a 10-day supply however she believed that the provider who is a new APRN since the original one who ordered it, put in multiple refills. The expectation however was that the medication was re-ordered when there were four of six pills remaining which would be a two- or three-day supply. The provider could be contacted to reorder as the prescriber can do so electronically. If there are none remaining, then a nurse should get the 50 mg dose from the Pixus to administer to the resident. Review of the Medication Shortages/Unavailable medications facility policy directed is a medication shortage is noted at the time of medication administration; the licensed nurse must immediately initiate action to obtain the medication and not wait until the medication pass is complete. If a medication shortage is noted after normal pharmacy hours a licensed nurse obtains the ordered medication from the emergency stock supply. Review of the Medication Ordering system policy directed reorder for on demand systems should occur when seventy hours of supply remain. Review of the Automated Dispensing Medication Dispensing system policy directed medications may be removed from the automated dispensing device following the devices instructions for medication needed on a PRN (as needed) basis. 3. Resident #64's diagnoses included type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue, and Parkinson's disease. The Resident Care Plan (RCP) dated 10/22/25 identified Resident #64 had pain that may impact mobility, mood, sleep, and relationship to others. Care plan interventions directed to determine level of pain using pain scale, administer medication as ordered, report unrelieved pain to the physician, and watch for nonverbal signs and symptoms of increasing pain. The 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] identified Resident #64 had intact cognition, required extensive assistance with bed mobility, toileting, hygiene, transfers, and ambulation, utilized a rolling walker and wheelchair for mobility, and frequently complained of (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moderate to severe pain. The physician's order dated 12/2/25 directed to apply lidocaine external patch 4 percent (local anesthetic) to the left shoulder for pain daily. The physiatry progress notes dated 12/16/25 identified Resident #64's pain was re-evaluated and identified that he/she disliked the lidocaine patches because it easily fell off and the note further identified a recommendation to use diclofenac sodium gel 4 gram to the left shoulder and left hip three times per day. The physician order dated 12/16/25 directed to apply diclofenac external gel 1 to 4.5 percent (analgesic anti-inflammatory), apply topically to the left shoulder three times a day for pain. The physiatry progress note dated 12/18/25 identified Resident #64 was not receiving the diclofenac gel to the left hip and left shoulder. In addition, the note identified that it was discussed with the facility nursing staff that the diclofenac medication had been ordered and was not available at the facility at that time. The physician order dated 12/22/25 directed to apply diclofenac sodium external gel 1 percent apply 4 grams topically to the left hip three times a day for pain daily. Review of the Medication Administration Record (MAR) from 12/16/25 to 12/22/25 identified that the diclofenac sodium external gel was being recorded as administered however, the diclofenac sodium external gel was not available in the facility during that period. Interview with LPN #8 on 12/23/25 at 2:55PM identified that she administered a muscle rub in replacement for the diclofenac as written in the physician orders. She identified that she had called the pharmacy and the pharmacy identified they were not providing over the counter (OTC) medication. LPN #1 stated she spoke with APRN #1 regarding substituting the diclofenac with the muscle rub. She further identified that she should have obtained a new order from the APRN #1 for the muscle rub until the diclofenac was available, but she did not obtain a new order and instead she had been administering the muscle rub without a physician order. Interview with APRN #1 on 12/29/25 at 10:45 AM identified that the nursing staff should administer the medication written in the physician orders. She identified that the muscle rub was not the same ingredients as the diclofenac. Although the muscle rub was not the same as the diclofenac, it was not harmful to the resident. She could not recall whether the nursing staff notified her that the diclofenac was not available, but stated she would have ordered the muscle rub until the diclofenac became available. Interview with the DNS on 12/30/25 at 10:30 AM identified that the nursing staff should administer medication exactly as written in the physician's order. She identified that the nursing staff should not substitute any Over The Counter (OTC) medication without obtaining a new order from the physician. The Medication Administration policy identified that all medications shall be administered safely and accurately in accordance with the physician's orders, facility protocol, and applicable state and federal guidelines.

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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** Based on observations, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for the one sampled resident (Resident #42) reviewed for respiratory care, the facility failed to provide respiratory care and services as ordered by the physician (failed to deliver humidified oxygen as ordered), failed to notify the physician when there was a change in oxygen equipment, failed to ensure oxygen equipment was used according to the manufacturer specifications (application of the non-rebreather without the appropriate oxygen flow rate, or reservoir inflated), and failed to have trained, competent, qualified staff to provide oxygen therapy services. The findings include:Resident #42 was admitted to the facility October 2025 with diagnoses that included systemic Lupus Erythematosus, coronary artery disease, vitamin D deficiency and unstable angina. (No specific respiratory diagnosis)The admission Minimum Data Set (MDS) dated [DATE] identified Resident #42 had intact cognition, required supervision or touching assistance with chair/bed to chair transfer, and bed mobility.The care plan dated 10/22/25 identified Resident #42 required staff assistance with ADL's related to weakness with interventions to assist with mouth/dental care, toileting needs as needed, set-up for meals, keep commonly used/needed articles in reach. The care plan identified Resident #42 was at risk for cardiac issues related to cardiovascular disease and hypertension with interventions for oxygen therapy as ordered.Physician's order dated 10/28/25 directed administration of oxygen via nasal cannula with humidifier at 2 liters as needed to keep the blood oxygen level above 90%. A physician's order dated 11/3/25 directed addition of a humidifier bottle to O2 due to nasal dryness every evening shift. (there was not a physician's order that pre-dated 10/28/25).Observations of Resident #42 over the course of the survey 12/22, 12/23, 12/24, 12/29 and12/30 identified oxygen administration via nasal cannula without humidification.Review of the EMS report dated 10/27/25 identified upon EMS arrival Resident #42 was noted to have a non-rebreather in place without the reservoir bag inflated and flowing oxygen at 2 liters per minute.Interview with the responding EMT on 12/24/25 at 8:27 AM identified that when EMS responded to a 911 call made by Resident #42, Resident #42 was found in the resident room in bed with a non-rebreather in place without the reservoir bag inflated and flowing oxygen at 2 liters per minute. The EMT indicated that Resident #42 identified the call to 911 was for chest pain and indicated he/she felt suffocated.Observation of Resident #42 on 12/23/25 at 1:30 PM identified Resident #42 had an oxygen condenser unit in the resident room that was set to 2 liters per minute and attached was a nasal cannula that Resident #42 had in place. The oxygen did not have a humidifier attached.Observation on 12/24/25 at 10:35 AM identified Resident #42 was wearing a nasal cannula attached to the oxygen condenser with oxygen set at 2 liters per minute but did not have a humidifier attached.Interview with LPN#4 on 12/24/25 at 9:24 AM identified the first step for complaints of a dry nose with oxygen use is to make sure the oxygen was humidified. LPN#4 confirmed Resident #42's order and indicated that humidified oxygen should be in use according to the order. LPN#4 identified that a non-rebreather mask would not be appropriate for use with the room oxygen condensers and identified the respiratory supplies were kept in the storage area. LPN#4 went to the storage room and indicated that there were no other masks to use except the non-rebreather masks and breathing treatment masks.Interview with the Emergency Medical Technician (Person #2) on 12/24/25 at 9:27 AM identified he responded to Resident #42's 911 call on 10/27/25 and found Resident #42 with a non-rebreather mask in place with the reservoir bag not inflated and with a low oxygen flow.Interview with LPN#5 on 12/24/25 at 10:12 AM identified she was the LPN taking care of Resident #42 on 10/27/25 on the evening shift and indicated that LPN#5 replaced Resident#42's nasal cannula and administered a breathing treatment. LPN#5 identified that Resident #42 was placed on the bubbler, referring to the humidified oxygen and offered nasal saline. LPN#5 identified that she had notified the supervisor and was asked not to go back into Resident #42's room after that point. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN#5 indicated Resident #42 asked for a mask, but she was not aware of who placed the non-rebreather on Resident #42 and did not see the resident with the non-rebreather in place. LPN#5 identified she was on a break when the EMTs responded to the facility.Interview with Resident #42 on 12/24/25 at 10:35 AM identified he/she had complained of a bloody nose and indicated that there were a lot of staff in his/her room. Resident #42 indicated that one of the staff members placed the mask on her face, although Resident #42 could not identify which staff member placed the mask. Resident #42 indicated he/she had the mask on for about an hour and did experience difficulty breathing and called 911 independently of the facility. Resident #42 identified that the mask had a bag attached that was not inflated and indicated that the responding EMTs explained that was not the way to use that mask.Interview with the Nurse Educator on 12/29/25 at 2:15 PM identified that although respiratory training was provided at the facility, the respiratory education dated August 2025 failed to include NA#5, LPN#5, nor the other NA working the unit on the date of the incidentObservation on 10/29/25 at 2:45 PM identified Resident #42 was wearing a nasal cannula with 2 liters of oxygen flowing but did not have humidification.Interview with the DNS on 12/29/25 at 9:35 AM identified she observed Resident #42 on 10/27/25 at around 4:30 PM and indicated Resident #42 had complained of a nosebleed and issues with the nasal cannula and was offered nasal saline but refused. The DNS identified that she was going to notify the practitioner of what Resident #42 was reporting but could not recall if that was done. The DNS could not recall if the oxygen contained a humidifier at the time. observed Resident #42 on 10/27/25 at around 4:30 PM and indicated Resident #42 had complained of a nosebleed and issues with the nasal cannula and was offered nasal saline but refused. The DNS identified that she was going to notify the practitioner of what Resident #42 was reporting but could not recall if that was done. The DNS could not recall if the oxygen contained a humidifier at the time.Interview with NA#5 on 12/29/25 at 3:14 PM identified she was working on 10/28/25 in the evening and recalled that Resident #42 had asked for a mask rather than the nasal cannula because of nasal bleeding but that NA#5 did not give the resident a mask, see Resident #42 with a mask, or know how Resident #42 received anything other than a nasal cannula at that time. NA#5 indicated that if she thought a resident needed a different oxygen device, she would notify the nurse.Interview with RN#3, RN Supervisor (RN#3) on 12/29/25 at 3:22 PM identified she was working on the evening of 10/26/25 as the nursing supervisor but was not aware that the non-rebreather masks were accessible for use. RN#3 indicated that she did not know who would have provided or placed the non-rebreather on Resident #42. RN#3 identified that if she had to go to get the non-rebreather and a different oxygen tank, she would just have called 911. RN#3 indicated that if Resident #42 needed an intervention other than the prescribed nasal cannula, a respiratory assessment should have been complete by the nurse, and the doctor would have to be notified of the need for the change.Interview with the medical supply representative on 12/30/25 at 10:42 AM identified that the facility ordered and received 5 simple masks on 11/3/25 but had not ordered or received any simple masks in the 12 months prior to this date.Interview with the Administrator on 12/29/25 at 2:06 PM identified he investigated the complaint from the EMTs and indicated he could not determine who put the non-rebreather mask on the resident but confirmed that Resident #42 was observed wearing the non-rebreather by staff although the Administrator could not identify which staff observed Resident #42 with the mask in place.Interview with LPN#3 on 12/30/25 at 11:05 AM identified Resident #42's active physician's order directed oxygen be administered at 2 liters per minute, humidified via nasal cannula and identified that Resident #42 was using oxygen that was not humidified.Interview with APRN#1 on 12/30/25 at 11:15 AM identified the expectation was for staff to follow orders as they were written and to notify the physician if there were concerns or changes needed. APRN#1 indicated that use of the non-rebreather would require a doctor's order and high flow oxygen which would not be available on the resident room oxygen concentrators.Interview with the Medical Director on 12/30/25 at 2:33 PM identified she expected oxygen to be administered to residents as ordered by the doctor and that Resident #42 should be receiving humidified oxygen if that (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was how it is ordered. The Medical Director indicated that a non-rebreather should not be used with low flow oxygen and would require an MD order to change the method of delivery from the ordered nasal cannula.Review of facility respiratory training for 2025 identified use of a non-rebreather should be ordered by the provider and used with high flow oxygen. Although the facility provided appropriate respiratory education, the LPN and both NAs responsible for Resident #42's care did not receive the training.Review of facility policy for oxygen administration identified the purpose for use of the non-rebreather mask was to deliver high flow oxygen through nose and mouth, per the physician's order (generally 10-15 LPM). Additionally, the policy indicated that oxygen flow rate should maintain reservoir bag at least one third to one-half full-on inspiration and are generally used for emergent situations and only for short periods of time.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, and interviews for one sampled resident (Resident #74) reviewed for resident assessment, the facility failed to ensure the MDS was coded accurately to reflect the current wheelchair mobility status of the resident. The findings include:Resident #74's diagnoses included severe protein calorie malnutrition, Marfan syndrome, osteoarthritis, and Alzheimer's.The physician's order dated 5/16/25 directed to have one person assist with bed mobility, two people assist with transfer, and non-ambulatory.The Occupational Therapy (OT) evaluation and plan of treatment dated from 5/21/25 to 8/11/25 identified Resident #74 required partial to moderate assistance with wheelchair mobility.The quarterly MDS assessment dated [DATE] identified Resident #74 had severe cognitive impairment and was dependent on staff for toileting, personal hygiene, dressing, transfers, and was non-ambulatory. Further review of the assessment identified Resident #74 was coded as independent for wheelchair mobility. The Physical Therapy (PT) evaluation and plan of treatment dated from 9/19/25 to 12/10/25 identified Resident #74 was dependent on staff for wheelchair mobility.The quarterly MDS assessment dated [DATE] identified Resident #74 had severe cognitive impairment and was dependent on staff for toileting, personal hygiene, dressing, transfers, and was non-ambulatory. Further review of the assessment identified Resident #74 was coded as independent for wheelchair mobility. The Resident Care Plan (RCP) dated 10/6/25 identified Resident #74 had limited physical mobility related to weakness and impaired balance. The care plan interventions directed the assistance of 1 person for bed mobility, toileting, assist of 2 people for transfers, and non-ambulatory. Observation on 12/24/25 at 10:10 AM identified Resident #74 sitting in a wheelchair with leg rests in place and the wheelchair was locked near the nurse station.Interview with NA #1 on 12/24/25 at 10:25 AM identified she was the regular nursing aide for Resident #74 on 7 AM -3 PM shift. She identified Resident #74 was dependent on staff for personal hygiene, toileting, dressing and required two people assist for transfer and he/she was not ambulatory. In addition, she identified that Resident #74 required staff assistance with wheelchair mobility and he/she could not self-propel while sitting on a wheelchair. She further identified that Resident #74 could not self-propel for over a year after he/she broke a hip.Interview with LPN #1 (MDS Coordinator) on 12/29/25 at 11:10 AM identified that she was responsible for coding section GG of the MDS assessment. She identified that she would make her own observation of the resident during the look back period and code the section GG based on her observations. She further identified that Resident #74 was independent with wheelchair mobility.Interview with OT #1 on 12/30/25 at 8:50 AM identified that she had treated Resident #74 for functional wheelchair mobility and identified Resident #74 required 2 people assist for transfer, and max assistance to total dependent with wheelchair mobility. She identified that Resident #74 was not independent with wheelchair mobility. Interview with OT #2 on 12/30/25 at 11:40 AM identified that Resident #74 was totally dependent for personal hygiene, toileting, transfer, non-ambulatory, and wheelchair mobility. She identified that Resident #74 was not independent with wheelchair mobility in the nursing unit and had a pending order for a customized wheelchair.The Resident Assessment Instrument (RAI) manual 3.0 in part of section GG functional abilities and goals indicated that a qualified clinician would code the data element based on the type and amount of assistance provided by a helper to reflect the resident's functional abilities.