STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075384	A. Building B. Wing	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlborough Health & Rehabilitation Center	85 Stage Harbor Road Marlborough, CT 06447

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491 Based on clinical record reviews, facility policy and interviews for 1 of 4 sampled residents (Resident #64) reviewed for Advanced Directives, the facility failed to update the advanced directive consent form for a code status change. The findings include: Resident #64's diagnoses included dementia, cognitive communication deficit, and psychotic disorder. A review of Resident #64's Advanced Medical Directive form dated [DATE] directed to perform Cardiopulmonary Resuscitation (CPR) and artificial respiration. A physician's order dated [DATE] directed to not Intubate, resuscitate, or tube feed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #64 as moderately cognitively impaired and required extensive assistance with dressing, eating, and personal hygiene. A review of Advanced Practice Registered Nurse (APRN#1) note dated [DATE] at 12:49 PM indicated the advanced care plan date was reviewed/completed and directed to not resuscitate, Intubate, or tube feed. Interview with Registered Nurse (RN#4) on [DATE] at 11:33 AM identified advanced directives were reviewed during the care plan meeting on [DATE] at 12:43 PM with no changes made to Resident #64's advanced directives. RN#4 referred to the banner in the computerized chart when referring to Resident #64's code status, which directs to not Intubate, resuscitate, or tube feed. Furthermore, RN#4 identified a discrepancy of what the advanced directive consent form, dated [DATE], indicated in the paper chart and what the advanced directive orders indicated in the electronic medical record. Interview with the Director of Nursing Services on [DATE] at 12:00 PM identified an updated and signed advanced directive consent form was required with any changes to a resident's advanced directive and could not provide evidence why the form was not updated. Review of the Advanced Directive Policy given during the survey indicated surrogate consent for a Do Not Resuscitate Order (DNR). order must be in writing, signed in the presence of two witnesses [AGE] years of age or older, who must sign the consent/Medical Orders for Life Sustaining Treatment/Physician Orders for Life Sustaining Treatment/Clinician Orders for Life Sustaining Treatment form.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, facility documentation, and interviews for 1 of 3 residents (Resident #35) reviewed for an allegation of abuse, the facility failed to ensure that resident was free from physical abuse. The findings include: Resident #35 's diagnoses included Parkinson's Disease, olecranon bursitis, and dystonia. The 5-day Minimum Data Set assessment dated [DATE], identified Resident #35 was cognitively intact and required extensive assistance for bed mobility, toileting, and personal hygiene, and was totally dependent on staff for transfers. The Resident Care Plan dated 2/15/22 identified Resident #35 had an activities of daily living deficit. Interventions included assistance of 1-2 for all activities of daily living. Review of the Nurses Note dated 2/15/22 at 4:09 PM, identified that during a Resident Care Plan (RCP) meeting Resident #35 informed Social Worker #1 that on 2/14/22, during the 3:00 PM to 11:00 PM shift, at approximately 9:30 PM, NA #3, had taken Resident #35's blood pressure with a wrist blood pressure cuff and tried to twist his/her wrist to which s/he replied that hurt and his/her wrist did not turn that way. Additionally, Resident # 35 told Social Worker #1 that NA #3 refused to empty his/her fecal containment bag, and s/he rang the call bell too much. Resident #35 indicated this caused him/her mental distress and increased anxiety. Review of Reportable Event form dated 2/15/22 indicated that Resident #35 reported NA#3 twisted his/her wrist while using a wrist blood pressure cuff and hurt his/her wrist. Additionally, Resident #35 requested NA#3 to empty his/her ostomy bag. NA#3 refused and stated that Resident #35 rang the call bell too much. Review of the Nursing Pain Tool dated 2/14/22 and signed on 2/18/22 identified Resident # 35 complained of mild right wrist pain. Review of NA #3's (undated) investigation statement failed to identify a problem with any of the residents or that she had failed to answer call lights. Review of LPN #4's investigation statement dated 2/15/22 identified during an RCP meeting, NA #3 had twisted his/her right arm during a blood pressure check and refused to empty his fecal collection bag. Resident #35 indicated NA #3 was intentionally being mean, and s/he no longer wanted NA #3 to care for him/her. Interview with LPN #4 on 8/10/23 at 3:22 PM identified that she was unable to recall any details of the incident, despite reading her statement to her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of LPN #1's investigation statement dated 2/15/22, identified that Resident #35 informed her that s/he was upset because his/her fecal collection bag was not emptied by NA #3. LPN #1 indicated that she emptied Resident #35's bag and spoke with NA #3 to notify her when the bag needed to be emptied. Interview with LPN #1 on 8/10/23 at 3:15 PM identified that she emptied Resident #35's fecal collection bag but could not remember details from that far back, or how long Resident #35 had to wait. Review of Social Worker #1's investigation statement dated 2/15/22 identified that during an RCP meeting, Resident #35 informed her s/he had requested NA #3 empty his fecal collection bag multiple times, but NA #3 refused. Additionally, NA #3 twisted his/her right arm during a blood pressure check and that s/he felt NA #3 was intentionally being mean, rude, and hurt him/her. Interview with Social Worker #1 on 8/15/23 at 3:15 PM identified that she could not remember the details of the allegation of abuse, however she would check her notes and return the call. Social Worker #1 failed to return the call. Attempts to interview NA #3 (who was no longer employed at the facility), and RN #3 were unsuccessful. Review of the facility summary dated 2/18/22 identified that the facility had found the allegation to be true. Review of facility's Abuse policy, revised on 1/2023 identified, in part, that each resident has the right to be free of abuse. Physical abuse includes hitting, slapping, pinching, and kicking, and that staff would refrain from all actions that could be considered abuse.

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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** 46046 Based on clinical record reviews, review of facility documentation, facility policy, and interviews for 2 of 4 sampled residents (Resident #20 and #64) reviewed for Advanced Directive, for 2 of 3 sampled residents (Resident # 34 and Resident #55) reviewed for accidents, and for the only sampled resident (Resident #4) reviewed for hearing impairment, the facility failed to review and revise the Resident Care Plan. The findings included: 1.Resident #20's diagnosis included Chronic Obstructive Pulmonary Disease, diabetes mellitus Type 2, and chronic kidney disease. A Resident Care Plan dated [DATE] for Advanced Directives code status as DNI/DNR/RNP (Do Not Intubate/Do Not Resuscitate/RN May Pronounce). Interventions included honoring advanced directives as directed by resident or designated power of attorney. A Care Plan Meeting note dated [DATE] indicated no documentation showing that the advance directive was or was not reviewed. A physician's order dated [DATE] directed Cardiopulmonary Resuscitation (CPR). A Significant Change in Status MDS assessment dated [DATE], identified Resident #20 as alert and moderately cognitively impaired, and required total dependence of two for transfers, extensive assistance of two for bed mobility, toilet use, extensive assistance of one for dressing, personal hygiene, and independence with set up for eating. An Advanced Practice Registered Nurse (APRN)'s progress notes dated ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE] indicated code status as DNR/DNI, RNP (Do Not Resuscitate/Do Not Intubate/Do Not Resuscitate). A Transfer/Discharge Report provided dated [DATE] indicated Advanced Directives: Cardiopulmonary Resuscitation; RN Pronouncement, death is anticipated due to illness, infirmity, or disease, any registered nurse employed by this facility is hereby authorized to pronounce death, this order must be renewed every 120 days. Interview and clinical record review with DNS on [DATE] at 8:28 AM identified Resident #20's hard chart copy identified two copies of Advanced Directives, one copy dated [DATE] which indicated DNR, and the copy dated [DATE] indicated CPR was to be administered. The DNS indicated she would remove the older copy and file the information in the medical records. Interview and multiple clinical record reviews of Resident # 20's advanced directives with LPN # #3 on [DATE] at 9:28 AM indicated she would first look in the resident's hard chart for Advanced Directives and compare it to what the gray area of clinical software indicated. She further identified Resident #20's record indicated Cardiopulmonary Resuscitation according to the gray area, and the paper Advanced Directives which were signed and dated by the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DNS on [DATE] at 10:22 AM identified that a nurse is aware of the code status once an advanced directive physician order is uploaded and transferred directly to the face sheet gray area. She further indicated that advanced directives are reviewed every quarter with the Power of Attorney (POA)/conservator/resident. She further indicated she was not able to provide the last staff education on advanced directives/code status as it is a standard of practice, there is a Medical Doctor (MD) order uploaded into PCC (Point Click Care (clinical charting software)) and reviewed at care plan meetings with the resident and family. She further indicated that a nurse would look at the face sheet first, then MD orders, and then the care plan if still unsatisfied. She further stated that at care plan meetings the MDS Coordinator and social worker are present, if changes are made in resident's advanced directives, the MD is notified and then we make changes. Interview and clinical record review with Registered Nurse (RN #2) on [DATE] at 8:50 AM identified that if a resident was found unresponsive, she would go to the face sheet, or to the document or sticker on the front of the chart. She proceeded to go into clinical software and indicated the care profile (gray area), and the MAR (Medication Administration Record) showed code status. She further indicated that sometimes she uses the hard copy chart as the doctor sometimes puts an order in there that may not have been transferred to clinical software yet. She indicated her first step is to look in the computer as well as on the Transfer/Discharge paper for this software system. Interview and clinical record review with APRN #1 on [DATE] at 1:55 PM identified the code status for Resident #20 in The Profile (gray banner area), and primary physician's note dated [DATE] directed code status as cardiopulmonary resuscitation (CPR). She further indicated that her [DATE] note indicated the resident as a DNR. Subsequent to inquiry, APRN #1 indicated that she would fix her notes to reflect that resident's code status to administer CPR. Interview and clinical record review with Licensed Practical Nurse (LPN #4) on [DATE] at 2:47 PM identified Resident #20's face sheet (gray banner), and physician's note dated [DATE] directed code status for cardiopulmonary resuscitation. Additionally, she identified the APRN's notes dated [DATE], and [DATE] indicated DNR/DNI RNP (RN may pronounce). She further noted that the care plan was last reviewed at the Resident Care Plan Meeting at the end of [DATE], was due this month ([DATE]), and the care plan dated [DATE] indicated Do Not Resuscitate. Interview and clinical record review with DNS on [DATE] at 2:57 PM identified code status for Resident #20's care plan indicated DNR/RNP, she further indicated the resident's care plan should indicate CPR. She additionally indicated that once an advanced directive is changed the care plan should be updated. Review of the facility policy dated ,d+[DATE], titled Advanced Care Planning Code Status indicated that a resident or surrogate may, at any time, revoke their consent to a D.N.R. order by making a written or oral declaration to a facility representative. The policy also indicated when the consent of the resident or surrogate has been obtained and the D.N.R. decision has been made, the directive shall be written as a formal order by the attending physician on the healthcare provider order sheet. The facts and considerations relevant to the D.N.R. decision shall be recorded by the attending physician in the progress notes. 2. Resident #64's diagnoses included dementia, cognitive communication deficit, and psychotic disorder. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated [DATE] directed do not intubate, resuscitate, or tube feed. Review of APRN #3's progress note dated [DATE] at 11:43 AM indicated Resident # 64's and family's wish were to change the resident's advanced directive to DNR. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #64 as moderately cognitively impaired and required extensive assistance with dressing, eating, and personal hygiene. Review of Resident #64's care plan dated [DATE] identified full code status. Interventions directed to refer to advanced directives for guidance and review advanced directives with resident and/or Power of Attorney on admission and at least quarterly. Interview with RN#4 on [DATE] at 11:33 PM identified advanced directives were reviewed during the care plan meeting on [DATE] at 12:43 PM with no changes made to Resident #64's advanced directives. RN#4 referred to the banner in the computerized chart when referring to Resident #64's code status, which directs to not intubate, resuscitate, or tube feed. Furthermore, RN#4 identified Resident #64's code status on the care plan dated [DATE] was not updated. Interview with the Director of Nursing Services (DNS) on [DATE] at 7:23 AM indicated changes to an advanced directive during a care plan meeting would be updated by one of the RN who attended the meeting. Furthermore, if the request to change the advanced directive was done via phone communication, two registered nurses would have to sign off on the change as well as update the advanced directive consent form. The DNS failed to identify why Resident #64's care plan was not updated with the new code status. Review of the Comprehensive Person-Centered Care Plan policy given onsite identified the care plan was developed to include information necessary to properly care for the resident and will address the resident's preferences, goals, and desired outcomes and would be periodically reviewed and revised by a team of qualified persons after each assessment or reassessment. 3. Resident #34's diagnosis included Neuropathy, diabetes mellitus, adjustment disorder with mixed anxiety and depressed mood. The quarterly MDS assessment dated [DATE] indicated Resident #34 was cognitively intact. The Resident Care plan dated [DATE] indicated Resident #34 was independent for meeting emotional, intellectual, physical, and social needs and may independently go out of the facility on leave of absences (LOA) and is self-responsible. Observation on [DATE] at 12:15 PM noted a small clear orange fluid filled device with a black trigger like at the top which Resident # 34 indicated was a butane lighter which was a memento from when he/she used to smoke but no longer smokes. The Administrator was immediately notified of the finding and the surveyor stayed outside the resident room until the administrator arrived who indicated s/he would investigate into the issue. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:00PM an interview with the Administrator indicated that after speaking with Resident #34 the lighter was removed. The Administrator also indicated letters went out to all families and responsible parties to inform them of items, including lighters were not allowed in the facility. The Administrator further indicated that Resident #34 signed a form that he/she was aware that lighters were not allowed in the facility. An interview with the DNS on [DATE] at 12:30 PM indicated that the resident care plan was updated to include an independent LOA order but was not revised to include having a lighter in the resident's possession. The DNS also indicated there was no documentation in the nurses' notes regarding the incident but would update the care plan regarding safety to reflect the occurrence. The care plan was revised on [DATE] to include an intervention Resident # 34 would not return from LOA with any contraband upon return to the facility. Interview with the DNS on [DATE]at 2:00 PM indicated upon return from LOA the receptionist asks residents if they have any items and if have items that are not allowed, they are asked to give to the receptionist for safe storage. The DNS further indicated there is a list of Independent LOA residents to have non-intrusive belongings search upon return from LOA and Resident #34 is included on that list. The facility policy labeled Clinical Services: Safe Unsupervised LOA Policy dated ,d+[DATE] indicated in part; the resident will be educated on the LOA policy, a list of residents with Independent Unsupervised LOA's will be kept by the supervisors and any resident found to be participating in potentially dangerous situations while on LOA a change may be needed to the resident's plan of care. 4. Resident #55's diagnosis' included Parkinson's disease, muscle weakness, and hemiplegia (paralysis of one side). The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #55 was severely cognitively impaired and required extensive assist of 1 person for transfers, toilet use and personal hygiene. The Resident Care Plan dated [DATE], identified that Resident #55 was at risk for falls. Review of facility Reportable Event documentation between [DATE] and [DATE] identified that Resident #55 had fallen 29 times. Review of the Reportable Event dated [DATE] identified that Resident #55 had fallen on [DATE]. A new intervention to move Resident #55 closer to the nursing station, which would be in a high traffic area, was implemented. Although Resident #55 fell on [DATE], review of the Resident Care Plan dated [DATE] failed to identify that the new intervention to move Resident #55 had been added to the care plan prior to [DATE]. Observation of Resident #55's current room on [DATE] at 1:38 PM identified he/she resided approximately two thirds of the way down the hall from the nursing station. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:14 PM with the DNS, identified that Resident #55's room had been changed to his/her current location (two thirds of the way down the hallway from the nursing station) on [DATE] due to the ineffectiveness of the intervention to prevent falls and to free up a short-term rehabilitation room. The DNS indicated that the care plan had been updated the previous day on [DATE] to reflect the change. Review of the paper copy of the Resident Care Plan for falls indicated that the intervention to keep Resident #55 close to the nursing station had discontinued (revised) on [DATE] which had been subsequent to surveyor inquiry. Re-interview with the DNS and interview with the ADNS on [DATE] at 3:08 PM, failed to identify why the care plan revision date, according to the previous interview, had been dated on [DATE], but the paper care plan copy reflected an updated care plan on [DATE]. The DNS was unable to explain the discrepancy. 5. Resident #4's diagnoses included bilateral hearing loss, anxiety, and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 was moderately cognitively impaired, had moderate hearing loss, and did not utilize hearing aids. Additionally Resident #4 required extensive assistance with bed mobility, transfers, and personal hygiene. The care plan dated [DATE] identified that Resident #4 had moderate difficulty hearing but chose not to wear hearing aids. Interventions included allowing adequate time to respond, repeat as necessary, and turn off the TV/radio to reduce environmental noise. Observation and interview with Resident #4 on [DATE] at 10:03 AM identified s/he would like his/her ear wax cleaned out and would like hearing aids. Resident #4 indicated that s/he told a NA, however, could not remember which one. Interview with NA #2 on [DATE] at 9:35 AM, identified she cared for Resident #4 regularly and Resident #4 did not wear, use, or have hearing aids. Interview with the DNS on [DATE] at 11:30 AM identified Resident #4 did not currently have hearing aids, did not have hearing aids upon admission, and could not identify why Resident #4 had a refusal to wear hearing aids since s/he did not wear or use hearing aids. Interview with the ADNS on [DATE] at 9:00 AM identified she had spoken with Resident #4's resident representative who indicated that Resident #4 had never had hearing aids. Resident #4's resident representative subsequently gave permission for an audiology (hearing) evaluation. Review of the Baseline/Comprehensive Person-Centered Care Plan policy, dated ,d+[DATE], identified, in part, that the care plan would be periodically reviewed and revised and kept current by all disciplines on an on-going basis. 47460 47491 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48879

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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** 29050 Based on observations, clinical record review, facility policy and interviews for 1 of 4 residents (Resident # 27) reviewed during the medication pass, the facility failed to ensure a medication was available for the resident as ordered by the physician to meet professional standards and for 1 of 3 residents reviewed for advance directives (Resident #134), the facility failed to ensure the code status was correctly reflected in the clinical record to meet professional standards. The findings include: 1. Resident # 27's diagnoses included in part, Chronic Obstructive Pulmonary Disease, hypokalemia (low potassium), hypertension and diabetes mellitus. The care plan dated [DATE] indicated that Resident # 27 had potential for an altered cardiovascular status related to hypertension and prolonged QT wave. Interventions included in part to observe changes in breathing and skin color, changes in weight or swelling and for symptoms of coronary heart disease. A physician's order dated [DATE] directed to administer Potassium Chloride Liquid 20 MEQ/15 ml, (10%) by mouth twice daily for hypokalemia (low potassium). The quarterly MDS assessment dated [DATE] indicated Resident # 27 was cognitively intact. Observation during the medication administration for Resident #27 on [DATE] at 8:30 AM with LPN #1 indicated s/he was unable to find potassium in the medication cart or in the medication room. LPN #1 indicated the pharmacy records indicated delivery of the medication at the end of [DATE] and would need to call them regarding the issue. No potassium was available to be given at the scheduled time as directed by the physician. Interview and record review with RN # 1 in the presence of APRN #1 on [DATE] at 1:25 PM indicated she was not made aware that there was no potassium for the 8:00 AM dose for Resident # 27 and the potassium was not administered as scheduled on [DATE] at 8:00 AM as ordered and would inform the APRN of the omission. RN #1 also indicated she would call the pharmacy to obtain the needed medication. APRN #1 indicated that he/she had not been informed by LPN #1 regarding the omission of the medication. A progress note dated [DATE] at 8:37 AM indicated in part that Potassium Chloride liquid to be given twice daily for hypokalemia (low potassium) was not available and the nurse would notify the pharmacy. Subsequent to inquiry, a progress note dated [DATE] at 1:39 PM indicated the missing medication was found in the medication cart and the writer spoke with the APRN who gave an order to administer the 8:00AM dose of potassium now. The APRN also directed staff to continue with the evening dose of potassium as ordered. The note further indicated the medication administration nurse was updated and administered the medication as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with RN #1 on [DATE] at 1:55 PM indicated if LPN #1 had informed him/her the potassium was not available he/she could have rechecked the medication cart and found the needed medication so it would have been administered timely. RN #1 further indicated that upon finding the potassium, she notified the APRN of the missed dose and obtained orders to administer a dose of potassium now and to continue with the scheduled dose due later this afternoon. The facility failed to ensure the resident's 8:00 AM administer Potassium Chloride Liquid 20 MEQ/15 ml as ordered by the physician on [DATE] at 8 AM and not administered 5 and a half hours after scheduled to meet professional standards. 2. Resident #134's diagnoses included cerebral palsy, septicemia, diabetes mellitus, malnutrition, and pressure ulcers. Another state agency form identified the Skilled Nursing Facility (SNF) required process for change in code status for Resident #134 dated [DATE] identified This document is NOT a Do Not Resuscitate (DNR) order. Further review identified individual is placed or treated under the direction of the another state agency Commissioner, which requires that any change in the individual's code status from full code to a DNR shall be completed with section 17a-238 of the Connecticut General Statues and the other state agency procedure I.E.PR.007c. Withholding Cardiopulmonary Resuscitation requires following the other state agency DNR Review process by contacting the other state agency case manager and the Appropriate Regional Health Services Director. Review of the Advanced Directive Consent/Acknowledgement and Release Form dated [DATE] identified that Resident #134's choices regarding the administration of life support systems were Cardiopulmonary Resuscitation and Artificial Respiration. The consent form was signed by power of attorney (POA), witnessed by registered nurse (RN) and on [DATE] signed by Nurse Practitioner (APRN #1). A physician's order dated [DATE] directed Cardiopulmonary Resuscitation (CPR) and Registered Nurse Pronouncement (RNP). Review of APRN #1 progress note dated [DATE] identified extensive discussion was held with Residents #134's POA regarding code status, advanced directives, end-of-life requests. POA confirmed she/he wanted the resident to be full code (CPR). The admission Minimum Data Set assessment dated [DATE] identified Resident #134 had severely impaired cognition, required extensive assistance with bed mobility, dressing and personal hygiene. Review of Resident #134's electronic clinical record 72 Hour/Initial Meeting dated [DATE] identified Resident #134's code status as DNI, DNR (Do Not Intubate/Do Not Resuscitate). Further review identified other state agency case manager will forward plan of care documents to facility, due to their role as guardian. The Resident Care Plan dated [DATE] identified Resident #134's advanced directives guidelines, code status as CPR and RNP. Interventions directed to honor advanced directives as directed by resident and/or power of attorney (POA) and to review advanced directives with the resident and/or POA on admission and at least quarterly. (continued on next page)

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	075384	A. Building B. Wing	08/14/2023

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Residents #134's electronic clinical record Summary of Baseline Care Plan dated [DATE] identified Resident #134's code status as DNI, DNR. The meeting with facility staff included Social Worker #2, Resident #134, the residents POA and other state agency staff. Interview with Social Worker #2 on [DATE] at 11:05 AM identified other state agency was the resident's guardian and the primary decision maker and should be contacted with any changes. She stated that she misread directions given by other state agency regarding Resident #134's code status. She could not remember if the resident's code status was reviewed with the attending participants during the care plan meetings on [DATE] and [DATE]. However, she incorrectly documented the resident's code status as DNI, DNR. Social Worker #2 further identified the documentation of code status for the resident should have been identified as full code, but she did not realize that until today. Interview with the DNS on [DATE] at 11:30 AM identified that meeting notes dated [DATE] and [DATE] were permanent records of Resident #134's electronic clinical record. During emergency situations, nursing staff does not review the meeting notes but instead follows the physician orders and residents wishes for advanced directives. Further review with the DNS identified the resident's clinical record, including meeting notes, should include correct documentation identifying that the resident's code status was full code. This was to prevent any possible mistakes or confusion regarding resident's code status. DNS identified that Social Worker #2 will receive in-services regarding accurately documenting residents code status following other state agency requirements, physician order and POA wishes. Review of the facility Medical Records policy directed the facility must maintain clinical records on each resident in accordance with accepted professional standards. Further review identified to assure that the facility maintains accurate, complete, and organized clinical information about each resident that is readily available for resident care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on observations and interview for 2 of 3 sampled residents (Resident #52 and Resident #55) reviewed for accidents, the facility failed to ensure the bathroom heating element was free from a fire hazard and failed to ensure a resident care plan intervention for falls was being implemented. The findings include: 1. Resident #52's diagnoses include bipolar disorder, depression, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #52 was alert and oriented and required extensive assistance with toilet use and personal hygiene. The Resident Care Plan (RCP) dated 7/14/23 identified Resident #52 was at risk for attention seeking behavior and impaired cognitive function. Interventions included assisting the resident to develop appropriate coping, interacting skills, and understanding limit setting. Observation on 8/7/23 at 11:00 AM of Resident #52's bathroom identified toilet tissue was wedged into the bathroom heating element. The heat was not in use. A second observation on 8/8/23 at 10:11 AM identified the toilet tissue remained in the same position in the heating element of the resident's bathroom. The heat was not in use. Interview with Housekeeper #1 on 8/8/23 at 10:14 AM indicted that housekeeping was responsible for maintaining the safe, clean environment in the resident's room and bathroom. Housekeeper #1 stated that, although, he cleaned the room the day before, he did not see the toilet tissue in the heating element. Housekeeper #1 immediately removed the toilet tissue from the heating element. The facility failed to ensure the Resident's environment is free from accident hazards by not ensuring the cleanliness and safety of the Resident's bathroom. 2. Resident #55' s diagnoses included Parkinson's disease, muscle weakness, and hemiplegia (paralyzed on one side) The quarterly Minimum Data Set assessment dated [DATE] identified Resident #55 was severely cognitively impaired and required the extensive assist of 1 person for transfers, toilet use, and personal hygiene. The Resident Care Plan dated 6/12/23 identified that Resident #55 was at risk for falls. Interventions directed to leave 2 urinals, at the bedside, at all times. Review of Reportable Event documentation between 11/30/22 and 8/7/23 identified that Resident #55 had 29 falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Reportable Event dated 7/3/23 identified that Resident #55 had fallen on 7/3/23 and that the new intervention to prevent future falls, was to place 2 urinals at the bedside at all times. Observations on 8/9/23 at 01:38 PM and 8/10/23 at 1:50 PM identified 1 urinal at the bedside. Observation and interview with NA #6 on 8/10/23 at 3:19 PM identified that Resident #55 had 1 urinal at the bedside. Interview with Resident #55 on 8/10/23 at 3:26 PM identified that s/he had 1 urinal at the beside and s/he was unable to locate a second urinal, including inside of his/her bed side stand or in his/her bathroom. Review of the facility ' s policy on the fall prevention program identified that the facility would develop interventions and incorporate them into the Resident Care Plan, as well as implementing an individualized activity plan. 48881

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46046 Based on observations, review of facility documentation, facility policy and interviews for 2 of 2 medication refrigerators, the facility failed to ensure the medication refrigerator temperature guideline was accurately monitored to meet regulatory requirements. The findings included: 1a. Observation and interview with LPN # 3 at 10:47 AM of the B- South medication room refrigerators indicated 2 separate refrigerator logs one for the medication refrigerator and one for the medication room nourishment refrigerator for the month of July 2023. The medication and nourishment refrigerator logs indicated a temperature guideline of 32-39 degrees Fahrenheit(F) and directed if temperatures were not within appropriate levels to notify the supervisors immediately and to document action taken. A sign posted with the nourishment refrigerator indicated to maintain refrigerator temperatures between 36- 46 degrees F. On 8/9/2023 at 11:15 AM interview and facility document review with LPN #3 noted the medication refrigerator log for July 2023 indicated on July 28, 2023, the medication refrigerator temperature was 34 degrees which was below the guideline on the posted sign (36-46) degrees, but within normal range on the refrigerator/freezer temperature log (32-39 degrees F.) Interview and facility document review with the DNS on 8/9/2023 at 11:30 AM and again at 12:00 Noon indicated the temperature log instructions were not accurate and s/he would investigate as well as consult with the pharmacist regarding the medications currently stored in the refrigerator under the recorded temperature conditions. The DNS further indicated the medication refrigerator should be kept between 32-39 degrees F. and indicated s/he would consult with the pharmacist regarding the status of the medications currently stored in the medication refrigerator. b. 8/10/2023 at 11:50 AM interview and observation of the Passport/A wing medication room with Nursing Supervisor, RN #1 indicated that the medication refrigerator log was recorded at 30 degrees on July 12, 2023, and the temperature log indicated that the medication temperature guideline was 32-39 degrees F. Nursing supervisor, RN# 1 Indicated he/she would consult with the DNS. On 8/10/2023 at 12:40 AM interview with the DNS who was made aware by the surveyor that the Passport/A wing Medication refrigerator had a temperature of 30 degree on one day. The DNS indicated she is in the process of producing new logs and would consult with the pharmacist regarding the medication stored in this medication refrigerator. On 8/10/2023 at 2:00 PM an interview with the DNS indicated he/she was still waiting to hear back from the pharmacist regarding the status of the medications stored in the med refrigerators on both the units. On 8/11/2023 at 10:30 AM the DNS provided written information from the pharmacist regarding the medications and the current medications are not affected. After surveyor inquiry, the DNS revised the medication temperature logs for the medication rooms and indicated he/she was in the process of in-servicing staff. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/2023 at 12:00PM an interview with Pharmacist #1 indicated his/her investigation of the medications that were stored in the medication refrigerators in both medication rooms, found no evidence in the prescribing information or literature for a temperature below 34 degrees for less than 24 hours that did not result in freezing and would have any effect medication stability of efficacy. Pharmacist #1 also indicated the medication that was stored in both medication refrigerators was able to be used. Pharmacist #1 further indicated that the medication refrigerator should be kept between 36 and 46-degrees F.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 47491 Based on interviews with residents, review of policy and staff interviews for 1 of 18 residents (Residents #' 34 and #44), the facility failed to ensure the residents were offered snacks. The finding include: Interview with Resident #22 on 8/9/23 at 12:01 PM indicated snacks were not being brought to floor and identified Resident #34 and Resident #44 had previously voiced their concerns regarding snacks. Resident #22 went to kitchen on 8/4/22 to address this issue and was told by kitchen staff it was too late to bring snacks to the floor and no one was available to bring snacks. Resident #22 was unable to identify the name of the kitchen staff s/he reported this to. Interview with NA #11 on 8/10/23 at 3:02 PM identified snacks have been coming late (9:00 PM) on the 300's unit. When the cart arrives, the NA's go around the unit and ask residents if they want a snack. NA #11 indicated snacks have been arriving on the unit late recently and residents were asleep by the time the NA's came around to offer snacks. Furthermore, NA # 11 indicated the snack basket was late on 8/7/23 and sometimes during the prior week and some residents were not offered a snack. NA #11 indicated if a resident were to come and ask for a snack, the NA would get them a snack if the snack basket was not brought to the unit. However, if a resident doe does not ask, the NAs would wait for the snack basket/cart to arrive before offering resident's a snack. An interview with the Dietary Services Manager on 8/14/23 at 10:50 AM identified snacks is available on a cart in each resident's wing and are brought out at 10:00 AM, 2:00 PM, and 8:00 PM. The Dietary Services Manager further indicated the cook will bring snacks to the resident's wing prior to leaving, each wing having their own snack cart which included cookies, graham crackers, ginger ale, and other beverages, and have sandwiches available in the kitchen refrigerator as well. The Dietary Services Manager also indicated residents will come to the kitchen if snacks are not brought to the resident's wings and that snacks are also left behind the nurse's station. Interview with Resident #34 on 8/14/23 at 11:18 AM identified snacks were hardly served on weekends and there was an issue with snacks being offered on second shift. Resident #34 indicated sometimes you don't get any snacks or hardly any snacks are sent to the unit, which frequently occurs on weekends. Interview with Resident #44 on 8/14/23 at 11:26 AM indicated there was an issue with snacks not being offered and with options. Resident # 44 residents was only offered graham crackers. Review of the Meal Frequency policy indicated snacks are offered to residents at bedtime and per their request.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48881 Based on observations, interviews, and facility policy, during the kitchen tour, the facility failed to ensure dishware was stored in a sanitary manner, failed to maintain the ice machine in a sanitary manner, failed to ensure the snack/nourishment refrigerator temperature was taken daily, and failed to ensure perishable food items in the snack/nourishment refrigerator were dated and labeled, to prevent the potential for foodborne illness. The findings include: 1. During the initial kitchen inspection, in the dishwashing area, with the Food Service Director, on 8/7/23 at 9:59 AM, newly washed dishes were observed stored in a dish rack. The clean dishware was noted to be directly in front of a running fan which was coated in dark debris clinging to both the exterior and interior of the fan blade guard blowing on the clean dishes. Interview with the Food Service Director on 8/7/23 at 10:15 AM identified that a dietary aid was responsible for the cleaning of the fan. The Food Service Director stated that the fan was cleaned by the dietary aid in the prior week and that the expectation was the fan would be cleaned weekly. The Food Service Director, however, identified that there was no policy pertaining to the cleaning of fans within the kitchen and that the dark debris needed to be cleaned from the fan. Interview on 8/7/23 at 10:20 AM with Dietary Aide #1 identified that her process for cleaning the fan would have been to remove the outer cage, clean the cage, and clean the blades of the fan. Dietary Aide #1 stated that she cleaned the fan last week, however, she could not remove the outer cage of the fan and could only wipe the outside of the cage. Dietary Aide #1 identified that she was not able to clean the inner cage guard. Dietary Aide #1 indicated that the fan was dirty and not properly cleaned. Subsequent to surveyor inquiry, the fan was turned off and cleaning of the fan was added to the list of kitchen cleaning duties. 2. Observation and interview on 8/7/23 at 12:00 PM with the Food Service Director identified the ice machine in the kitchen to have a black substance inside the upper lip of the door. The Food Service Director identified that the ice machine needed to be cleaned, immediately stopped all use of the ice machine, emptied the bin, and contacted the ice machine vendor for cleaning. Re-interview on 8/8/23 at 11:30 AM with the Food Service Director identified that the ice machine vendor was a new company, the ice machine was less than 6 months old, and cleaning was scheduled for every 6 months. The Food Service Director was unable to provide the date that the last cleaning was completed or when the machine was delivered. 3. Observation on 8/7/23 at 10:58 AM of the snack/nourishment refrigerator, in the Passport Hallway, identified the temperature log failed to include documentation of refrigerator temperatures being recorded between the dates of 8/3/23-8/6/23. Additionally, inside of the refrigerator, 4 resealable perishable food containers and 2 opened 2-liter bottles of soda were not labeled with a date and resident name. (continued on next page)

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	075384	A. Building B. Wing	08/14/2023

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/7/23 at 11:08 AM with the Director of Housekeeping identified that it is the responsibility of the unit housekeeping staff to record daily temperatures on the refrigerator log sheet and to ensure that any food or drink in the refrigerator was dated and labeled. Interview on 8/7/23 at 11:15 AM with Housekeeper #2 identified that she had the responsibility of performing the daily snack/nourishment refrigerator temperature checks and for ensuring all perishable food items in the refrigerator were dated and labeled. Housekeeper #2 indicated she had not monitored the refrigerator temperatures from 8/3/23-8/6/23 (4 days), because she had forgotten to take the temperatures. The facility policy for refrigerators and freezers revised on 1/2009 indicated, in part, that temperature readings will be taken and recorded on the daily refrigerator and freezer log. The facility policy on use and storage of food brought to residents by family and visitors, revised on 3/2022, indicated, in part, that perishable foods must be stored in the nursing unit kitchen nourishment refrigerator and identified with the resident's name, food item, and used by date.

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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. 29050 Based on staff interview and review of Payroll Based Journal (PBJ) submissions for Quarter 2 and 3, the facility failed to ensure staff was not excessively low on the weekend. The findings include: The PBJ Staffing Data Report for Quarter 3, 2022 (April 1, 2022 - June 30, 2022) and Quarter 2, 2022 (January 1 - 2022 March 31, 2022) identified submitted weekend staffing data was excessively low. Interview with the Director of Nursing Services (DNS) on 8/14/23 at 10:58 AM identified the facility was working with two staffing agencies and was actively hiring staff, mostly certified nurse's aides. The DNS indicated the facility was also utilizing unit helpers to perform non-nursing care duties, such as making resident's beds, responding to call bells, and communicating residents needs to licensed and certified staff. The DNS also indicated the facility has implemented an all-hands-on deck approach in assisting with resident care duties and responsibilities and the facility has implemented a bonus/incentive program for staff who pick up an extra eight-hour work shift. The DNS further indicated s/he will be meeting with the scheduler weekly on Wednesdays to discuss staffing needs and continued to utilize staffing agencies to secure staffing for weekend coverage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29050 Based on clinical record reviews, observations, and interviews for 1 sampled resident (Resident #35) reviewed for Foley catheter use, the facility failed to ensure the Foley catheter drainage bag was not on the floor, for 1 of 3 residents (Resident #134) reviewed for pressure ulcers, the facility failed to ensure that resident pressure ulcer treatment supplies were stored in a sanitary manner according to infection control practices and for 1 of 2 observed dining rooms during lunch meal service, the facility failed to ensure a clean environment .The findings included: 1.Resident #35 Diagnoses included in part Neuromuscular dysfunction of the bladder, Parkinsons disease, weakness, and hypertension. A Physicians order dated [DATE] directed to cleanse the suprapubic tube site with normal saline pat dry and cover with split gauze dressing and tape daily and as needed for displaced or soiled dressing. The quarterly MDS dated [DATE] indicated that Resident #35 was cognitively intact and had an indwelling urinary catheter (suprapubic tube). A Physicians order dated [DATE] directed to administer Macrobid oral capsule(antibiotic) 100 mg twice daily for urinary tract infection for 7 days. The care plan dated [DATE] for Resident # 35 indicated an Activity of Daily Living self-care deficit related to Parkinson's disease, weakness, and dystonia. The intervention included in part to provide extensive assistance of one person for toilet use. Observation on [DATE] at 6:35 AM Resident #35's urinary drainage bag was noted to be touching the floor while resident was sleeping in bed. Interview with LPN #2 on [DATE] at 6:38 AM indicated that the urinary drainage bag should not be touching the floor and would correct it immediately. Observation on [DATE] at 6:43 AM noted NA #1 adjusting the height of the urinary drainage bag on the bed frame, so it did not touch the floor. The facility policy titled Clinical Services, dated ,d+[DATE] indicated in part that a sterile, continuously closed drainage system should be maintained for indwelling and suprapubic catheter systems and that care should be taken to keep the outlet valve from becoming contaminated. 2. Resident #134's diagnoses included cerebral palsy, septicemia, diabetes mellitus, malnutrition, and pressure ulcers. The 5-day scheduled Minimum Data Set assessment dated [DATE] identified Resident #134 had severely impaired cognition, required total dependence with two staff members with transfers, locomotion, dressing and personal hygiene. (continued on next page)

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	075384	A. Building B. Wing	08/14/2023

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated [DATE] identified Resident #134 had an actual alternation in skin integrity. Interventions directed to monitor for signs and symptoms of infection (redness, swelling, drainage, odor, etc.), monitor wound vacuum for intactness and provide treatment as ordered. A physician's order dated [DATE] directed to cleanse sacrum wound treated with wound vacuum (negative pressure wound therapy) with normal saline, pat dry, pack wound with black foam, follow up Tegaderm dressing (transparent adhesive film dressing) then bridge with black foam every evening shift on Monday, Wednesday, Friday and as needed for soiling or dislodgment. The wound consultant Doctor of Osteopathic (DO)#2 pressure ulcer evaluation dated [DATE] identified Resident #134 with sacral stage IV pressure ulcer, measuring 7 centimeters (cm) by 7 cm by 0.5 cm and undermining measuring 1.5 cm. The pressure ulcer was noted with moderate amount of serous exudate and 70% granulation tissue. The evaluation further identified improvement, evidenced by decreased depth, increased granulation with directions to continue negative pressure wound therapy. Observation of Resident #134's room on [DATE] at 12:51 PM identified an opened carton box with multiple opened/exposed treatment supplies. The opened carton box was covering another carton box that was resting on the floor in the resident's room. Further observation identified next to the open carton box with exposed treatment supplies was a soiled laundry hamper. On top of the soiled laundry hamper was a plastic wash basin containing additional exposed treatment supplies and opened box of exposed vinyl exam gloves. Interview with LPN #6 (7:00AM-3:00PM shift charge nurse for Resident #134) on [DATE] at 1:10 PM identified she never provided wound dressing treatment to the resident so she did not pay attention to the supplies stored in the resident's room. LPN #6 further identified that treatment supplies should have been stored in the treatment cart but maybe staff left them in the resident's room for easy access. Interview with wound consultant DO #2 on [DATE] at 2:35 PM identified Resident #134 with sacral stage IV pressure ulcer and newly identified left ischium unstageable deep tissue injury that reopened again and required treatments. The resident had a history of wound infection and completed last antibiotics therapy on [DATE]. DO #2 identified that together with LPN #8, they completed a wound treatment to the resident's open areas before lunch time but used treatment supplies stored in the treatment cart. DO #2 further identified treatment supplies should not have been stored in the resident's room especially next to hamper containing soiled laundry due to potential infection problems. DO #2 instructed LPN #8 to throw away all treatment supplies in the garbage. (continued on next page)

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	075384	A. Building B. Wing	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlborough Health & Rehabilitation Center	85 Stage Harbor Road Marlborough, CT 06447

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LPN #8 on [DATE] at 2:44 PM identified the opened boxes with exposed treatment supplies on the floor and on top of the soiled laundry hamper belonging to Resident #134. LPN #8 further identified when she completed the resident's wound treatment before lunch time, she used the supplies from the treatment cart, although the treatment supplies in the resident's room were designated to be used for wound treatments for Resident #134 to be done as ordered by the physician. Further observation identified Resident #134's roommate was propelling himself/herself and stopped to watch television while in his/her wheelchair placed directly next to open treatment supplies. LPN #8 identified opened treatment supplies included: multiple large sheets of Tegaderm, pack of woven gauze sponges, package of sterile barrier island dressing, tube of Triad Hydrophilic wound dressing with missing cover (screw top), two 250 ml plastic bottles of sterile Normal Saline irrigation solution that were undated, one 250 ml plastic bottle of sterile Normal Saline irrigation solution that was dated [DATE], one 100 ml plastic bottle of sterile water for irrigation that was undated when opened, piston irrigation syringe with teared packaging. LPN #8 identified the treatment supplies should have been stored in the secured treatment cart, sterile water and sterile Normal Saline irrigation solution should have been dated and disposed of after being opened for 24 hours. LPN #8 immediately disposed of all treatment supplies in the resident's room. Interview with DNS on [DATE] at 3:10 PM identified she expected nurses to use treatment supplies stored in Resident #134's room because they were specifically ordered for the resident's wound dressing change and to reapply negative pressure wound therapy. Further interviews with DNS identified charge nurses were responsible to ensure residents' treatment supplies were stored in a sanitary manner, covered in sealed packaging, dated when opened and not expired and never stored directly on the floor. Interview with LPN #9 (3:00PM-11:00PM shift charge nurse for Resident #134) on [DATE] at 3:30 PM identified for treatments provided to Resident #134's wounds, she used the treatment supplies stored in the resident's room because they were designated for the resident. Review of facility Infection Control Wound Management Policy directed in part, various types of wounds, including pressure ulcers, diabetic, vascular, and surgical wounds, may be encountered and cared for in the facility. Implementing infection prevention practices during wound care is important to reduce the development of infections and the transmission of pathogens. 3. Observation on at [DATE] at 12:30 PM identified residents eating lunch in the dining room. A plastic sheathing was had been erected within the dining area and housed the following construction materials: Insulation Batting Dry wall Dry wall dust The plastic sheathing was noted to have gaps at the ceiling and a vertical tear allowing any particles of dust, debris, and insulation material to escape to where the residents were dining. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Adminisistrator on [DATE] at 1:45 PM identified that the sheathing did not serve as a sufficient barrier due to several openings and was not a material that could be cleaned. The Administrator indicated that the sheathing would be removed and the dining area would be terminally cleaned. 31357 46046 48335