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	06/20/2025

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 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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure the resident was assessed by a Registered Nurse (RN), after a fall with major injury, prior to being moved by staff. The findings include: Resident #1's diagnoses included dementia without behavioral disturbances, difficulty in walking, abnormalities of gait (walking) and mobility (the ability to move or be moved from one place to another) and muscle weakness. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8), required substantial assistance for toileting, personal hygiene and transfers and required partial assistance for bed mobility. The MDS identified Resident #1 did not exhibit behaviors. The Resident Care Plan (RCP) dated 5/31/25 identified Resident #1 was at risk for falls related to increased weakness to the lower extremities and a history of falls. Interventions included encouraging Resident #1 to be out of his/her room when awake for socialization and/or recreation and applying Dycem (a plastic silicone mat that creates a non-slip surface) under the wheelchair cushion to prevent sliding. The facility Reportable Event (RE) dated 5/31/25 identified that at 8:30 PM Resident #1 had a witnessed fall (by NA #1) out of the wheelchair, landing in a prone position (face first) on the floor of the bedroom and resulting in a contusion to the right forehead, a bruise to the right arm and pain to the right ankle. The RE identified the family was notified, the provider was notified, and an order was obtained to transfer Resident #1 to the Emergency Department (ED) for evaluation. A Situation, Background, Assessment and Recommendation (SBAR) note dated 5/31/25 at 9:16 PM by RN #1 identified Resident #1 was observed on the floor of his/her bedroom. Resident #1 reported sliding out of the wheelchair resulting in the fall. A bump was noted to Resident #1's right forehead, a bruise to the right arm and Resident #1 complained of pain to the right ankle on assessment. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Prehospital Care Report (ambulance run sheet) dated 5/31/25 identified Emergency Medical Services (EMS) was called by the facility at 9:27 PM (57-minutes after the fall) and responded to the facility at 9:45 PM. The report indicated that the facility reported Resident #1 was being helped from the bathroom when he/she fell, and hit his/her right forehead, right forearm and lower right leg on a dresser. It identified that when EMS arrived Resident #1 was in bed, was oriented to person, place, time and event and was observed with a one (1) inch by two (2) inch raised contusion (bruise) to the right forehead that stopped bleeding, as well as a 1 inch by 2 inch raised contusion to the right forearm, and Resident #1 complained of right lower leg pain. Review of hospital ED documentation dated 5/31/25 identified Resident #1 was seen subsequent to a witnessed fall where Resident #1 hit a dresser with his/her head but did not lose consciousness and was complaining of right arm and right lower leg pain that was worse on palpation. It identified that an abrasion (a superficial skin injury caused by scraping or rubbing) was noted to Resident #1's right forehead, swelling, tenderness and bruising was noted to the right forearm and tenderness was noted to the right lower leg. It identified that imaging was completed of the head, right forearm and right tibia fibula (lower leg bones) which identified small right frontal scalp soft tissue swelling and hematoma (a closed wound where blood pools and fills a space at a point of injury because it cannot flow or drain out) as well as acute displaced oblique fractures of the distal shaft of the tibia and fibula (a broken shinbone and calf bone near the ankle, with the break occurring at an angle and the bone fragments are slightly out of alignment). The note identified that due to Resident #1 being non-ambulatory, surgery was not an option, Resident #1 was placed in a splint, and was to be non-weightbearing until he/she followed up with outpatient orthopedics. Interview with Resident #1 on 6/20/25 at 10:21 AM identified that on 5/31/25, NA #1 was assisting him/her to get ready for bed in the bedroom bathroom. Resident #1 identified that NA #1 was rushed and indicated he did not assist him/her into the wheelchair correctly, as he/she was on the edge of the seat and not positioned back. NA #1 then started to push Resident #1 too fast into the room. Resident #1 reported that he/she told NA #1 to stop because he/she felt like he/she was going to fall, but NA #1 did not listen and Resident #1 fell forward out of the wheelchair. Resident #1 indicated the next thing he/she remembered was being on the floor in pain. Resident #1 identified Resident #2 (roommate) was sitting on his/her bed and witnessed the fall as the fall occurred right next to Resident #2's bed. Interview with Resident #2 (intact cognition: BIMS score of 15 on 3/20/25 and 6/20/25) on 6/20/25 at 10:32 AM identified he/she was sitting on the edge of his/her bed facing the bathroom door when he/she observed NA #1 pushing Resident #1 in his/her wheelchair out of the bathroom. Resident #2 identified Resident #1 was on the edge of the wheelchair and yelled, stop, stop but NA #1 did not stop, and Resident #1 fell forward out of the wheelchair, hit his/her head on Resident #2's dresser and the wheelchair fell on top of Resident #1. Resident #2 reported that the bedroom door was closed at the time of the fall and NA #1 pushed the wheelchair aside and attempted to lift Resident #1 up from the floor, as Resident #1 yelled in pain, but was unsuccessful, so he sat Resident #1 up and Resident #2 started to yell for help. Resident #2 identified that NA #1 did not use the call bell or attempt to get staff assistance following the fall, but staff responded after Resident #2 yelled for help. Three (3) staff members stood Resident #1 up and assisted him/her into bed. Resident #2 identified that OTA #1 (Rehab Manager) spoke with him/her and Resident #1 regarding the incident but neither the DNS nor any nursing staff interviewed him/her as a witness to the incident. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 6/20/25 at 11:12 AM identified that on 5/31/25, he brought Resident #1 into the bathroom to get him/her ready for bed and when he was finished, assisted Resident #1 back into the wheelchair and was not certain if Resident #1 was positioned all the way back in the wheelchair. He started to push Resident #1 in the wheelchair and identified Resident #1 yelled, stop, so he stopped, and thinks Resident #1 then self-propelled and quickly fell forward out of the wheelchair and hit his/her head on something. He identified the incident happened fast and he was unsure of what had happened. NA #1 identified the wheelchair fell on top of Resident #1 and he pushed it aside and moved Resident #1 onto his/her back because his/her face was pushed into the floor. He denied attempting to pick Resident #1 up but was unable to explain how Resident #1 got into a sitting position. NA #1 identified that Resident #1 was moaning in pain following the fall. Interview with OTA #1 (Rehab Director) on 6/20/25 at 12:20 PM identified Resident #1 was discharged from Physical Therapy (PT) services on 4/9/25 and, at that time, there were no safety concerns. OTA #1 further identified Resident #1 had overall decreased strength and he did not believe Resident #1 had the ability of moving from a stomach or back lying position to sitting up at 90 degrees independently, especially following a fall. Resident #1 required partial to moderate assistance at the time of therapy discharge on [DATE]. Interview with LPN #1 and review of statement dated 5/31/25 on 6/20/25 at 12:40 PM identified he was the first licensed nurse on scene following the incident. He reported that when he entered the room, Resident #1 was sitting on the floor in an upright position between the bathroom door and Resident #2's dresser, with a bleeding area to his/her right forehead and Resident #1's wheelchair was on its side next to Resident #1. He identified that NA #1 reported Resident #1 slid out of his/her wheelchair and hit his/her head and he (LPN #1) did not think Resident #1 had the ability to move from a lying to sitting position independently. He identified that after an RN assessment, NA #1, himself and a third staff member stood Resident #1 and assisted him/her into the wheelchair and then into bed. He reported he did not know how long Resident #1 was in bed prior to EMS arriving. Review of NA #2's statement dated 5/31/25 identified that on 5/31/25, she was in the hallway when she heard Resident #2 screaming for help. She identified she knocked on the door and when she opened it, Resident #1 was on the ground accompanied by NA #1. Interview with the DNS on 6/20/25 at 1:05 PM identified that LPN #1's written statement identified Resident #1 was observed on the floor in a sitting position after the fall, but she did not question NA #1 regarding whether he moved Resident #1 and was unaware that staff transferred Resident #1 into the wheelchair and then into the bed following the fall. She reported that when she conducted her interviews staff reported Resident #1 was never moved. Although attempted, interviews with RN #1 and NA #2 were not obtained. Review of the Accident/Incident policy dated 6/2024 directed, in part, that staff will notify the nursing supervisor /licensed nurse when an incident occurs. The licensed nurse or the nursing supervisor will complete and document the evaluation of the resident's condition. The licensed nurse or nursing supervisor records their investigative findings and conclusions in RMS. The DNS reviews RMS events to ensure accurate and complete documentation of the incident, and to determine if there is credible evidence to substantiate the allegations of abuse, neglect or mistreatment. The RMS and investigation will be reviewed by the Administrator, DNS and the Medical Director when completed. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Fall Prevention Program policy dated 3/2023 directed, in part, that if a fall occurs, keep the resident immobile until the resident is examined and determined to be free from fractures.

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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 0689 Level of Harm - 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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure that a resident was properly positioned in a wheelchair while being transported by staff. The resident fell from the wheelchair and suffered multiple serious injuries including a fractured tibia and fibula. The findings include: Resident #1's diagnoses included dementia without behavioral disturbances, difficulty in walking, abnormalities of gait (walking) and mobility (the ability to move or be moved from one place to another) and muscle weakness. A Fall Evaluation dated 8/5/23 identified that although Resident #1 was not a fall risk, he/she had the potential for a fall with/without injury. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8), required substantial assistance for toileting, personal hygiene and transfers and required partial assistance for bed mobility. The MDS identified Resident #1 did not exhibit behaviors. The Resident Care Plan (RCP) dated 5/31/25 identified Resident #1 was at risk for falls related to increased weakness to the lower extremities and a history of falls. Interventions included encouraging Resident #1 to be out of his/her room when awake for socialization and/or recreation and applying Dycem (a plastic silicone mat that creates a non-slip surface) under the wheelchair cushion to prevent sliding. The facility Reportable Event (RE) dated 5/31/25 identified that at 8:30 PM Resident #1 had a witnessed fall (by NA #1) out of the wheelchair, landing in a prone position (face first) on the floor of the bedroom and resulting in a contusion to the right forehead, a bruise to the right arm and pain to the right ankle. The RE identified the family was notified, the provider was notified, and an order was obtained to transfer Resident #1 to the Emergency Department (ED) for evaluation. A Situation, Background, Assessment and Recommendation (SBAR) note dated 5/31/25 at 9:16 PM by RN #1 identified Resident #1 was observed on the floor of his/her bedroom. Resident #1 reported sliding out of the wheelchair resulting in the fall. A bump was noted to Resident #1's right forehead, a bruise to the right arm and Resident #1 complained of pain to the right ankle on assessment. A Fall Evaluation dated 5/31/25 at 9:51 PM identified Resident #1 was a low fall risk. Review of the Prehospital Care Report (ambulance run sheet) dated 5/31/25 identified Emergency Medical Services (EMS) was called by the facility at 9:27 PM (57-minutes after the fall) and responded to the facility at 9:45 PM. The report indicated that the facility reported Resident #1 was being helped from the bathroom when he/she fell, and hit his/her right forehead, right forearm and lower right leg on a dresser. It identified that when EMS arrived Resident #1 was in bed, was oriented to person, place, time and event and was observed with a one (1) inch by two (2) inch raised contusion (bruise) to the right forehead that stopped bleeding, as well as a 1 inch by 2 inch raised contusion to the right forearm, and Resident #1 complained of right lower leg pain. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of hospital ED documentation dated 5/31/25 identified Resident #1 was seen subsequent to a witnessed fall where Resident #1 hit a dresser with his/her head but did not lose consciousness and was complaining of right arm and right lower leg pain that was worse on palpation. It identified that an abrasion (a superficial skin injury caused by scraping or rubbing) was noted to Resident #1's right forehead, swelling, tenderness and bruising was noted to the right forearm and tenderness was noted to the right lower leg. It identified that imaging was completed of the head, right forearm and right tibia fibula (lower leg bones) which identified small right frontal scalp soft tissue swelling and hematoma (a closed wound where blood pools and fills a space at a point of injury because it cannot flow or drain out) as well as acute displaced oblique fractures of the distal shaft of the tibia and fibula (a broken shinbone and calf bone near the ankle, with the break occurring at an angle and the bone fragments are slightly out of alignment). The note identified that due to Resident #1 being non-ambulatory, surgery was not an option, Resident #1 was placed in a splint, and was to be non-weightbearing until he/she followed up with outpatient orthopedics. Interview and observation of Resident #1 on 6/20/25 at 10:21 AM identified that on 5/31/25, NA #1 was assisting him/her to get ready for bed in the bedroom bathroom. Resident #1 identified that NA #1 was rushed and indicated he did not assist him/her into the wheelchair correctly, as he/she was on the edge of the seat and not positioned back. NA #1 then started to push Resident #1 too fast into the room. Resident #1 reported that he/she told NA #1 to stop because he/she felt like he/she was going to fall, but NA #1 did not listen and Resident #1 fell forward out of the wheelchair. Resident #1 indicated the next thing he/she remembered was being on the floor in pain. Resident #1 identified Resident #2 (roommate) was sitting on his/her bed and witnessed the fall as the fall occurred right next to Resident #2's bed. Resident #1 was observed with a bump to his/her right mid forehead, bruising to the right mid-arm and a pink cast was in place from below the knee to above the toes. Interview with Resident #2 (intact cognition: BIMS score of 15 on 3/20/25 and 6/20/25) on 6/20/25 at 10:32 AM identified he/she was sitting on the edge of his/her bed facing the bathroom door when he/she observed NA #1 pushing Resident #1 in his/her wheelchair out of the bathroom. Resident #2 identified Resident #1 was on the edge of the wheelchair and yelled, stop, stop but NA #1 did not stop, and Resident #1 fell forward out of the wheelchair, hit his/her head on Resident #2's dresser and the wheelchair fell on top of Resident #1. Resident #2 reported that the bedroom door was closed at the time of the fall and NA #1 pushed the wheelchair aside and attempted to lift Resident #1 up from the floor, as Resident #1 yelled in pain, but was unsuccessful, so he sat Resident #1 up and Resident #2 started to yell for help. Resident #2 identified that NA #1 did not use the call bell or attempt to get staff assistance following the fall, but staff responded after Resident #2 yelled for help. Three (3) staff members stood Resident #1 up and assisted him/her into bed. Resident #2 identified that OTA #1 (Rehab Manager) spoke with him/her and Resident #1 regarding the incident but neither the DNS nor any nursing staff interviewed him/her as a witness to the incident. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #1 on 6/20/25 at 11:12 AM identified that on 5/31/25, he brought Resident #1 into the bathroom to get him/her ready for bed and when he was finished, assisted Resident #1 back into the wheelchair and was not certain if Resident #1 was positioned all the way back in the wheelchair. He started to push Resident #1 in the wheelchair and identified Resident #1 yelled, stop, so he stopped, and thinks Resident #1 then self-propelled and quickly fell forward out of the wheelchair and hit his/her head on something. He identified the incident happened fast and he was unsure of what had happened. NA #1 identified the wheelchair fell on top of Resident #1 and he pushed it aside and moved Resident #1 onto his/her back because his/her face was pushed into the floor. He denied attempting to pick Resident #1 up but was unable to explain how Resident #1 got into a sitting position. NA #1 identified that Resident #1 was moaning in pain following the fall. Interview with OTA #1 (Rehab Director) on 6/20/25 at 12:20 PM identified Resident #1 was discharged from Physical Therapy (PT) services on 4/9/25 and, at that time, there were no safety concerns. He indicated therapy worked with Resident #1 in the wheelchair and if there were concerns of the cushion sliding, that would have been addressed prior to discharging Resident #1 from services. OTA #1 identified Resident #1 was safe to self-propel in the wheelchair, and if Resident #1 was positioned upright and all the way back in the wheelchair with his/her hips positioned correctly, it would be unlikely for Resident #1 to slip off the edge of the wheelchair if self-propelling from the doorway of the bathroom to the roommates dresser (five (5) to ten (10) feet away). OTA #1 identified Resident #1 did not have a history of slipping out of the wheelchair. OTA #1 further identified Resident #1 had overall decreased strength and he did not believe Resident #1 had the ability of moving from a stomach or back lying position to sitting up at 90 degrees independently, especially following a fall. Resident #1 required partial to moderate assistance at the time of therapy discharge on [DATE]. OTA #1 identified that following any resident fall, he speaks with the resident, and identified he spoke with both Resident #1 and Resident #2 after Resident #1's fall out of the wheelchair. He identified that both Resident #1 and Resident #2 reported Resident #1 was on the edge of the wheelchair seat while NA #1 was pushing him/her and that Resident #1 requested NA #1 stop pushing him/her but NA #1 continued to push Resident #1 which resulted in the fall. OTA #1 identified he reported both Resident #1 and Resident #2's account of the incident to the DNS and also spoke about it in morning report the following day and thought the information he provided should have been investigated. An Occupational Therapy Evaluation & Plan of Treatment note dated 6/3/25 identified Resident #1 was referred following a witnessed fall out of his/her wheelchair. The note identified that per Resident #1 and Resident #2, a Nurse Aide (NA #1) was assisting Resident #1 out of the bathroom in his/her wheelchair, but Resident #1 was sitting at the edge of the wheelchair, the Nurse Aide went too fast, and Resident #1 fell out of the wheelchair and hit his/her head on a dresser. The note identified that on evaluation, Resident #1 presented below his/her baseline and required a Hoyer lift assist of two (2) staff for transfers out of bed and bed level Activities of Daily Living (ADLs) and Resident #1 was previously an assist of one (1) for toileting and ADLs at the wheelchair level. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with LPN #1 and review of statement dated 5/31/25 on 6/20/25 at 12:40 PM identified he was the first licensed nurse on scene following the incident. He reported that when he entered the room, Resident #1 was sitting on the floor in an upright position between the bathroom door and Resident #2's dresser, with a bleeding area to his/her right forehead and Resident #1's wheelchair was on its side next to Resident #1. He identified that NA #1 reported Resident #1 slid out of his/her wheelchair and hit his/her head and he (LPN #1) did not think Resident #1 had the ability to move from a lying to sitting position independently. He identified that after an RN assessment, NA #1, himself and a third staff member stood Resident #1 and assisted him/her into the wheelchair and then into bed. He reported he did not know how long Resident #1 was in bed prior to EMS arriving. Review of NA #2's statement dated 5/31/25 identified that on 5/31/25, she was in the hallway when she heard Resident #2 screaming for help. She identified she knocked on the door and when she opened it, Resident #1 was on the ground accompanied by NA #1. Interview with the DNS on 6/20/25 at 1:05 PM identified her investigation revealed Resident #1 told NA #1 to stop while he was pushing him/her in the wheelchair out of the bathroom, and she thought he stopped and Resident #1 self-propelled prior to sliding out of the wheelchair. She identified it was reported by OTA #1 that Resident #1 and Resident #2 reported Resident #1 was on the edge of the wheelchair and NA #1 continued pushing Resident #1 after he/she told him to stop. She identified she spoke with OTA #1 about the incident and spoke with Resident #2, but could not recall the specifics except that Resident #2 reported he/she was in bed at the time of the incident. The DNS indicated she did not believe Resident #2 could see the fall from where he/she (Resident #2) was positioned so did not further investigate. The DNS was unable to provide documentation of the conversation with Resident #2 or a statement from Resident #2 which she indicated should have been documented as part of the investigation. The DNS identified she did not question NA #1 on whether he moved Resident #1 after the fall and was unaware that staff transferred Resident #1 into the wheelchair and then into the bed following the fall. She reported that when she conducted her interviews staff reported Resident #1 was never moved. The DNS identified she was unsure why EMS was not called until 57-minutes after the fall. Although attempted, interviews with RN #1 and NA #2 were not obtained. Review of the Accident/Incident policy dated 6/2024 directed, in part, that staff will notify the nursing supervisor /licensed nurse when an incident occurs. The licensed nurse or the nursing supervisor will complete and document the evaluation of the resident's condition. The licensed nurse will complete an investigation for accidents/incidents. The investigation will include written statements from staff members caring for the resident and from people having knowledge of the event. If the resident makes a statement, their statement is to be included. The licensed nurse or nursing supervisor records their investigative findings and conclusions in RMS. The DNS reviews RMS events to ensure accurate and complete documentation of the incident, and to determine if there is credible evidence to substantiate the allegations of abuse, neglect or mistreatment. The RMS and investigation will be reviewed by the Administrator, DNS and the Medical Director when completed. Review of the Fall Prevention Program policy dated 3/2023 directed, in part, that if a fall occurs, keep the resident immobile until the resident is examined and determined to be free from fractures.