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	04/15/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 documentation/policies, and staff interviews, for one (1) of one (1) sampled resident (Resident #6) reviewed for management and monitoring of hypertension, the facility failed to report elevated blood pressures to the physician and failed to establish clear parameters for reporting abnormal blood pressure readings in the absence of specific physician orders. The findings include:Resident #6's diagnoses included hypertension, intracerebral hemorrhage, acute respiratory failure hypoxia with tracheostomy, hemiplegia, and seizures.Physician's orders dated 4/9/25 directed all medications be administered through the gastrostomy tube (g-tube). Medications for hypertension included Amlodipine ten (10) milligrams (mg) one (1) tablet daily, carvedilol 6.25 mg every twelve (12) hours, clonidine HCl 0.2 mg every 12 hours, hydralazine 50 mg every four (4) hours, spironolactone 12.5 mg 1 tablet daily, and losartan potassium 100 mg 1 tablet daily.Documented blood pressures identified an admission blood pressure on 4/9/26 of 130/83 and elevated blood pressures on 4/10/26 (169/84); 4/11/26 (148/89 and 151/81); and 4/12/26 (188/100 and 192/98) with warning alerts generated on the vital sign report for systolic high of 139 exceeded.Review of the clinical record from 4/10/26 to 4/12/26 failed to identify the physician was notified of elevated blood pressures on 4/10/26 and 4/11/26.The admission Minimum Data Set assessment dated [DATE] identified Resident #6 was severely cognitively impaired and unable to make reasonable and consistent decisions regarding tasks of daily living (Brief Interview for Mental Status (BIMS) score of 2), was dependent on all care including bed mobility and transfers.The Resident Care Plan (RCP) dated 4/12/25 identified Resident #6 had hypertension with interventions that directed to administer medications as ordered, monitor for abnormal cardiac symptoms, check vital signs per facility protocol, and monitor for change in lung sounds.The nurse's note dated 4/12/26 at 12:00 PM by RN #2 (the 7:00 AM to 3:00 PM supervisor) identified Resident #6 was assessed due to a change in condition. RN #2 identified Resident #6 as lethargic, warm, and clammy, and had vomited medication. The head of the bed was elevated at ninety (90) and Resident #6 was suctioned due to increased secretions. Resident #6's blood pressure was 188/100 manually. The physician was notified and Resident #6 was sent to the Emergency Department (ED) for possible aspiration or hypertension urgency due to elevated blood pressure and lethargy.The ED note dated 4/12/26 identified Resident #6 as a chronically ill-appearing resident distressed and diaphoretic. A CT scan of the head identified an acute intracranial hemorrhage involving the right temporal lobe with a small amount of subarachnoid and subdural blood. Resident #6 was started on nicardipine by intravenous route for elevated blood pressure and transferred to the hospital that had recently treated him/her for management of an intracranial hemorrhage. Interview with LPN #4 on 4/15/26 at 11:00 AM identified she provided care for Resident #6 on 4/11/26 and 4/12/26. She did not recall if Resident #6 had parameters in place for reporting elevated blood pressures and further identified the facility did not have parameters established for reporting elevated blood pressures. LPN #4 identified she would report an elevation in blood pressure if the systolic was over 160 or 170 or if the diastolic was over eighty. LPN #1 took Resident #6's blood pressure on 4/11/26 at 151/81 and failed to report the (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	diastolic elevation based on her identified parameters.Interview with LPN # 3 on 4/15/26 at 1:30 PM identified she did not know if the facility had parameters in place for reporting elevated blood pressures and she would report to the supervisor if the systolic blood pressure was over 150 or 160 or if the diastolic blood pressure was over 90. LPN #3 took Resident #6's blood pressure on 4/10/26 at 169/84 and failed to report the systolic elevation based on her identified parameters. She further identified she rechecked the blood pressure but failed to document the results.Interview with the DON (Director of Nursing) on 4/15/26 at 2:45 PM identified that facility staff should report elevations in blood pressure based on the physician's orders, and in the absence of orders, should follow the Care Path Symptoms of Acute Mental Status Change that identified reporting a blood pressure elevation over 200 systolic. The DON further identified that all obtained vital signs should be documented. Interview with LPN #2 on 4/15/26 at 3:10 PM identified she would report elevations in blood pressure if the blood pressure was approaching 150/99 after checking the resident's baseline.Although attempted, a call was not returned by MD #1.Although requested, the facility did not have a policy for reporting abnormal vital signs in the absence of acute mental status changes.The facility Change in Condition Policy identified, in part, that when the staff identified the change of condition, they notify the licensed nurse, and the licensed nurse completes a physical evaluation and documents the findings in the medical record. The facility must inform the resident and consult with the resident's healthcare provider of significant change in the resident's physical condition.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, video footage, and facility documentation/guidelines, for one (1) of three (3) sampled residents (Resident #1) reviewed for abuse, the facility failed to ensure written consent was obtained and required timeframes were followed prior to the installation and use of video monitoring. This resulted in unauthorized visual and audio access to Resident #1's care, interactions, and environment. The findings included:Resident #1 was admitted to the facility in December of 2024 and had diagnoses which included dementia, schizoaffective disorder, bipolar type, and anxiety disorder.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6), required supervision/touch assistance with toileting, dressing, and personal hygiene and use of a wheelchair for transport.The Resident Care Plan (RCP) dated 1/9/26 identified Resident #1 had the potential to be physically and verbally aggressive related to dementia with poor impulse control and psychotropic medication use related to post traumatic stress disorder, major depressive disorder, and schizoaffective disorder. Interventions directed to provide physical and verbal cues to alleviate anxiety, give positive feedback, assist to set goals for more pleasant behavior, encourage seeking out staff members when agitated and to allow the resident to vent frustrations.A nurse's note by LPN #8 on 3/10/26 at 11:59 AM identified he/she spoke with Resident #1's responsible party regarding the roommate's request to install a camera in the room to observe the roommate. LPN #8 assured the responsible party that the camera would not monitor Resident #1, the responsible party expressed understanding and verbal consent was obtained to install the camera. LPN #8 explained the policy and that the responsible party would need to sign consent. An email was sent to the responsible party as requested, awaiting return of signed paperwork. Interview with SW #1 on 4/9/26 at 2:32 PM identified the video camera was installed by the facility, on the roommate's side of the room, on 3/10/26.Review of video footage dated 3/12/26 at 5:51 PM identified Resident #1 received an assisted wheelchair transport into his/her room, was struck twice by a staff member, and captured audio of Resident #1's verbal outburst. The video footage further captured part of the hallway outside of Resident #1's room, the shared bathroom, all parties entering the room or walking by the doorway and enabled monitoring of the inside of the bathroom if the bathroom door was left open. Although verbal consent was received for the installation of the video camera on 3/10/26, the Roommate Virtual Monitoring Technology Consent Form was signed on 3/16/26 which agreed to virtual monitoring, with the understanding that Resident #1's roommate may only begin using the electronic technology device seven (7) days after submitting a notice and consent (written document) to the facility. Therefore, the video camera should not have been installed prior to 3/23/26 and provided unauthorized access to Resident #1's daily care, treatments, practices, and interactions.Interview with the Director of Nursing Services (DNS) on 4/9/26 at 3:14 PM confirmed the video camera should not have been installed until after written consent was obtained and no sooner than seven (7) days following the date of the signed consent form, in accordance with the facility's agreement and applicable guidelines. The DNS acknowledged the consent form was signed on 3/16/26, establishing the earliest allowable installation date as 3/23/26. The DNS was unable to explain why the camera was installed on 3/10/26, prior to obtaining written consent and outside of the required waiting period.Although requested, the facility did not have a virtual monitoring policy. However, the facility provided the following guidelines regarding virtual connections: The State of Connecticut House of Representatives File #627, which both the Resident Virtual Monitoring Technology Consent Form and Instructions and Roommate Virtual Monitoring Technology Consent Form were modeled after. Review of the State of Connecticut House of Representatives File #627, an act concerning the rights of residents in nursing home facilities to use the technology of their choice for virtual connections to the family, friends, and other persons identified the resident or resident (continued on next page)

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	075384	A. Building B. Wing	04/15/2026

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	representative was to file a signed, written notice with the nursing home facility and a copy of any written consent of any roommate not less than seven (7) days before installing or using such technology for virtual monitoring that identified the type of technology, its intended use, intended hours of operation and location of such technology in the room or living quarters, whether the technology was capable of recording audio or video or being activated or controlled remotely, acknowledged that the resident was responsible for the purchase, activation, installation, maintenance, repair, operation, deactivation and removal of such technology, and included a waiver of all civil, criminal, and administration liability for the nursing home facility in accordance with subsection (d) of this section.The Residents' [NAME] of Rights Policy identified a resident's right to privacy in accommodation, in receiving personal and medical care and treatment; in visits and in meetings with family and resident groups, in written, spoken, telephonic, and electronic communications, including email and video communications and in internet research; the right to associate and communicate privately with persons of your choice, including other residents.

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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 0600 Level of Harm - 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** Based on observation (video), interviews, and record/policy review, the facility failed to ensure Resident #1 remained free from abuse when Nurse Aide (NA) #1 deliberately struck the resident's head during transport to the resident's room on 03/12/2026 at ~5:51 PM, causing an actual psychosocial outcome (yelling with audible distress) to a severely cognitively impaired resident (BIMS=6). Specifically, the video shows NA #1 entering the room, striking the top of the resident's cap, then striking the left side of the resident's head with the left hand while passing the roommate's bed; a loud noise is heard immediately before the resident yells. The facility's Abuse Policy prohibits willful infliction of injury, intimidation, or punishment resulting in physical harm, pain, or mental anguish, yet NA #1's actions violated this requirement. While RN #1 assessed no physical injury and the facility notified the DNS and police and removed NA #1, the resident nonetheless experienced actual psychosocial harm under the reasonable person standard. The findings included:Resident #1 was admitted to the facility in December of 2024 and had diagnoses which included dementia, schizoaffective disorder, bipolar type, and anxiety disorder.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6), required supervision/touch assistance with toileting, dressing, and personal hygiene and use of a wheelchair for transport.The Resident Care Plan (RCP) dated 1/9/26 identified Resident #1 had the potential to be physically and verbally aggressive related to dementia with poor impulse control and psychotropic medication use related to posttraumatic stress disorder, major depressive disorder, and schizoaffective disorder. Interventions directed to provide physical and verbal cues to alleviate anxiety, give positive feedback, assist to set goals for more pleasant behavior, encourage seeking out staff members when agitated and to allow the resident to vent frustrations.Review of camera footage dated 3/12/26 at 5:51 PM identified NA #1 transporting Resident #1 into his/her room via wheelchair. After entering the room, NA #1 struck the top of the resident's baseball cap with his/her left hand and then struck the left side of the resident's head with his/her left hand while passing the roommate's bed. Resident #1's arms remained positioned on the wheelchair armrests during the incident. Camera visibility was partially obstructed beyond the roommate's bed area; however, a loud noise was heard, followed by Resident #1 yelling. NA #1 was then observed re-entering the camera's view and then re-approaching Resident #1's side of the room again before the footage ended.A nursing note by RN #1 on 3/12/26 at 8:00 PM identified Person #1 reported alleged abuse of a resident by a staff member. The Director of Nursing Services (DNS) and the police were notified. A Headˆtoˆtoe assessment was conducted, and no injury was noted. The resident was unable to give details of the incident due to dementia. The resident's sister was notified, the provider and APRN #1 were updated.A statement by NA #1 dated 3/12/26 identified he/she was helping Resident #1 back to his/her room when he/she noticed Resident #1's hat was coming off. NA #1 indicated he/she pushed it down to secure it, Resident #1 reached for the hat again, and NA #1 helped Resident #1 adjust it again. NA #1 further indicated Resident #1 got frustrated, tried to pick up the dinner tray (which made a loud noise), and after noticing Resident #1 was frustrated, NA #1 backed up and left the room. Interview with RN #1 on 4/8/26 at 10:38 AM identified he/she was informed of the 3/12/26 incident by Person #1 between 6:00 PM and 6:30 PM via phone call as Person #1 observed the incident in real time via the roommate's livestream camera. RN #1 indicated he/she reviewed the camera footage provided, immediately directed NA #1 to wait outside of the facility, notified appropriate staff and police, assessed Resident #1 and found him/her without injury. Interview with NA #1 on 4/8/26 at 11:36 AM failed to provide details of the 3/12/26 incident, however, indicated a statement provided to the facility was available for review. Interview with the DNS on 4/8/26 at 12:20 PM identified NA #1's actions were inappropriate and no resident was to be struck, at any time, (continued on next page)

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	075384	A. Building B. Wing	04/15/2026

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F 0600 Level of Harm - Actual harm Residents Affected - Few	regardless of the situation at hand. The DNS further identified the facility's standard of practice was that all residents were to always be kept safe and free from harm. The Abuse Policy and Procedure identified each resident has the right to be free from abuse, neglect, and misappropriation of resident property and exploitation and defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. PAST NON-COMPLIANCE The facility presented a corrective action plan dated 3/12/26 which included:-Body audits and nursing assessments performed to residents on 3/12/26 who may have received care from the alleged perpetrator.-Resident interviews and precautionary resident assessments completed by 3/13/26 for other facility residents.-Staff education dated 3/12/26 included: abuse prevention, including definitions of abuse, resident rights, mandatory reporting requirements, and the facility's zero tolerance policy.-Additional education provided included: staff burnout, stress management, and appropriate de-escalation techniques when caring for residents. -Residents on affected unit interviewed by social services to ensure residents felt safe and to identify any additional concerns.-Review of employee personnel files, including background checks, abuse registry verification, and required competencies to ensure compliance with hiring and training requirements.-Reinforcement of appropriate resident care, professional conduct, and reporting responsibilities during staff meetings and daily stand-up huddles.-Abuse prevention audits which included random resident interviews, staff interviews, and leadership observational rounds to evaluate staff interactions with residents.-Audits of staff performing care by nursing leadership to ensure appropriate resident interactions and adherence to abuse prevention policies to be conducted weekly for four (4) weeks, then monthly for three (3) months until substantial compliance is achieved.-Results will be reviewed by the QAPI committee to ensure sustained compliance and identify any additional opportunities for improvement.-Concerns identified through monitoring will result in immediate corrective action and additional staff education as needed.-The DNS was responsible for this corrective action plan.-The corrective action plan was accepted by the state agency during an onsite visit on 4/8/26.

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	075384	A. Building B. Wing	04/15/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 clinical record review, facility documentation, facility policy, and interviews, for one (1) of one (1) sampled resident (Resident #6) reviewed for an acute change in condition, the facility failed to provide adequate supervision and monitoring for a dependent resident experiencing an acute change in condition after Emergency Medical Services (EMS) was activated. This failure resulted in the resident being left unattended despite a compromised medical status, placing the resident at risk for aspiration and airway compromise. The findings include:Resident #6's diagnoses included hypertension, intracerebral hemorrhage, acute respiratory failure hypoxia with tracheostomy, hemiplegia, gastrostomy tube feed, and seizures.The admission Minimum Data Set assessment dated [DATE] identified Resident #6 was severely cognitively impaired and unable to make reasonable and consistent decisions regarding tasks of daily living (Brief Interview for Mental Status (BIMS) score of 2), was dependent on all care including bed mobility and transfers.The Resident Care Plan (RCP) dated 4/12/25 identified Resident #6 had hypertension, a self-care deficit, a tracheostomy, and had a g-tube for feeding. Interventions directed to administer medications as ordered, monitor for abnormal cardiac symptoms, check vital signs per the facility protocol, provide complete care including repositioning, suction as needed, monitor respiratory and cardiac status.The nurse's note dated 4/12/26 at 12:00 PM by RN #2 (the 7:00 AM to 3:00 PM supervisor) identified Resident #6 was assessed due to a change in condition. RN #2 identified Resident #6 as lethargic, warm, and clammy, and had vomited medication. The head of the bed was elevated at ninety (90) and Resident #6 was suctioned due to increased secretions. Resident #6's blood pressure was 188/100 manually. The physician was notified and Resident #6 was sent to the Emergency Department (ED) for possible aspiration or hypertension urgency due to elevated blood pressure and lethargy. The nurse's note dated 4/12/26 at 12:05 PM by RN #2 identified at 11:30 AM after Resident #6 vomited, the tube feeding was turned off and the head of bed was elevated at 90 . Resident #6 vomited again. Lungs were clear and Resident #6 had positive bowel sounds. Skin was clammy and warm and Resident #6 was very lethargic. The family was called and was present during transfer to the ED. The ED note dated 4/12/26 identified Resident #6 as a chronically ill-appearing resident distressed and diaphoretic. A CT scan of the head identified an acute intracranial hemorrhage involving the right temporal lobe with a small amount of subarachnoid and subdural blood. Resident #6 was started on nicardipine by intravenous route for elevated blood pressure and transferred to the hospital that had recently treated him/her for management of an intracranial hemorrhage. Interview with LPN #4 on 4/15/26 at 11:00 AM identified she administered medications to Resident #6 the morning of 4/12/26 and Resident #6 was at baseline tracking with his/her eyes. Shortly after 11:00 AM, LPN #4 entered Resident #6's room to administer more medications and Resident #6 was less responsive, tracked with his/her eyes but did not hold a gaze. LPN #4 administered the medications and returned fifteen (15) minutes later to find Resident #6 had vomited, his/her skin was clammy, and blood pressure was elevated. LPN #4 turned off the tube feeding and called RN #2 to the room. After assessing Resident #6, RN #2 left his/her room to call 911, the family, and completed paperwork, LPN #4 proceeded to pass medications to other residents. LPN #4 further identified no one was in Resident #6's room until after Resident #6's family arrived at the facility. Once EMS arrived, LPN #4 had to suction Resident #6 again and the resident vomited during transfer to the ambulance stretcher. LPN #4 further identified someone should have stayed with the resident until EMS arrived on scene.Interview with NA #7 on 4/15/26 at 2:05 PM identified on 4/12/26 after 911 was called, she did not continuously stay with Resident #6 until EMS arrived and there was no nurse in the room during that time.Interview with the DON (Director of Nursing) on 4/15/26 at 2:45 PM identified that facility staff should provide supervision to any resident after 911 was called until the EMS arrived and due to the condition of Resident #6 it was a concern that no one stayed with him/her.Although requested, policies for (continued on next page)

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	075384	A. Building B. Wing	04/15/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Emergency Response, 911 Activation, Aspiration Precautions, and Supervision / Accident Prevention were not provided.

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	075384	A. Building B. Wing	04/15/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 clinical records, staff interviews, camera footage, and facility documentation, for one (1) of three (3) residents (Resident #1) reviewed for accident hazards, the facility failed to ensure leg rests were in place during an assisted wheelchair transport. This failure placed the resident at risk for injury. The findings included:Resident #1 was admitted to the facility in December 2024 and had diagnoses which included dementia, schizoaffective disorder, bipolar type, and anxiety disorder.Review of the Wheelchair Competency for NA #1 dated 7/29/25 identified he/she had successfully performed all competency elements, which included to ensure the resident's feet were placed safely on the footrests.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Mental Interview for Mental Status (BIMS) of 6), required supervision/touch assistance with toileting, dressing, and personal hygiene and use of a manual wheelchair for transport.The Resident Care Plan (RCP) dated 1/9/26 identified Resident #1 had a deficit in functional mobility. Interventions directed use of a standard wheelchair with anti-rollbacks due to Resident #1's inability to walk.Review of camera footage dated 3/12/26 at 5:51 PM identified NA #1 transporting Resident #1 into his/her room via wheelchair without attached leg rests and Resident #1 intermittently placing his/her feet on the floor while receiving assisted transport. Resident #1 presented agitated during the wheelchair transfer.Interview with PT #1 on 4/8/26 at 1:15 PM identified Resident #1 did not have the ability to raise his/her legs for an extended period while receiving assisted transport and required constant cueing/multiple reminders to raise his/her legs while receiving assisted transport as he/she would frequently rest his/her feet on the floor. PT #1 further indicated the risk for a resident who placed his/her feet on the floor while receiving assisted transport was injury and potential ejection from the wheelchair.Interview with NA #1 on 4/8/26 at 3:45 PM identified facility practice was to attach leg rests to a resident's wheelchair prior to assisted transport.Interview with the Director of Nursing Services (DNS) on 4/8/26 at 4:12 PM identified Resident #1 should have had leg rests attached to his/her wheelchair when he/she received assisted wheelchair transport on 3/12/26. The DNS further identified if leg rests were refused, the staff member should have sought an alternate means of transport to ensure the resident's safety and avoid the risk of injury. The DNS indicated staff received education in 2025 regarding assisted wheelchair transport which included the attachment of leg rests. Although requested, the facility did not have a policy for assisted wheelchair transport.