STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225063	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlborough Hills Rehabilitation & Hlth Care Ctr	121 Northboro Road Marlborough, MA 01752

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was admitted to the Facility with a history of suicidal ideations and self-injurious behavior, the Facility failed to ensure Resident #1's Comprehensive Care Plan (CPs), which although they included some interventions related to self injurious behaviors, that they were reviewed and/or revised for effectiveness when he/she continued to gain access to objects that he/she used to threaten self harm with. Findings included: Review of the facility's policy, titled Comprehensive Care Plans, date revised 11/2017, indicated the following: -The facility is committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life. -Recognizing each resident as an individual, we identify those needs in a resident-centered environment. -The Interdisciplinary Team (IDT) develops a comprehensive Care Plan for each resident that includes measurable objectives and timelines to accommodate preferences, special medical, nursing, and psychosocial needs identified. -The care plan is evaluated and revised as needed, but at least quarterly. Resident #1 was admitted to the Facility in March 2025, diagnoses included suicidal ideations, major depressive disorder, unspecified dementia, and delusional disorders. Review of Resident #1's Dietary Care Plan, included an intervention initiated on 03/10/25 to provide plastic utensils with all meals. Review of Resident #1's Nursing Progress Note, dated 03/28/25, indicated staff found Resident #1 with a [metal] fork, trying to stab him/herself and Resident #1 was transferred to the Hospital Emergency Department (ED) for an evaluation. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's medical record indicated he/she returned to the facility on [DATE]. Review of Resident #1's Comprehensive Care Plan, indicated there was a new focus area, dated 04/03/25 which included that Resident #1 had a history of suicidal attempts; most recently on 03/28/25. -The Care Plan interventions included: *Monitor the need for psychosocial, psychiatric support, *Psychotherapy weekly for one month and then as needed, * Staff to provide frequent rounding on the resident. Review of Resident #1's Nursing Progress Note, dated 04/05/25, indicated Resident #1 was observed with a plastic knife in his/her right hand and a [superficial] cut to his/her left forearm; Resident #1 made continual suicidal ideation statements and was transferred to the Hospital ED for an evaluation. Review of Resident #1's Nursing Progress Note, dated 04/10/25, indicated Resident #1 returned from the hospital. Review of Resident #1's Dementia Care Plan, indicated Resident #1 had suicidal ideations and suicide attempts, a new intervention was added for 1:1 monitoring by staff during meal times, was initiated on 04/11/25. Review of Resident #1's Nursing Progress Note, dated 05/08/25, indicated Resident #1 had taken a metal fork and broke off three of the four prongs and attempted to stab him/herself. The Note indicated Resident #1 was transferred to the Hospital ED for an evaluation and returned to the facility later that evening. Review of Resident #1's Care Plan for history of suicidal attempts, indicated a new intervention was added on 05/08/25 for every 15-minute head checks [per staff, 15 head checks were for 72 hours only]. Despite Resident #1's Care Plan interventions that he/she was only to have plastic utensils, and for staff supervision during meal times, on two separate occasions he/she was able gain access to and physically alter a metal fork then use it to threaten self harm. There were no additional care plan interventions developed or implemented that focused on how to prevent Resident #1 from gaining access to items he/she could use to inflect self harm. During an interview on 05/21/25 at 1:33 P.M., the Director of Nurses (DON) said that Resident #1 was placed on every 15-minute head checks for 72 hours following each incident and Resident #1 was no longer on them. The DON said that despite the interventions in Resident #1's care plan, he/she was able to obtain silverware on multiple occasions.

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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 - 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** 37086 Based on records reviewed, interviews and observation, for one of three sampled residents (Resident #1), who had a history of suicidal ideation with threats of self harm with metal and plastic utensils, the facility failed to ensure they provided an adequate level of staff supervision in an effort to maintain a safe environment for Resident #1, when he/she was able to gain access to a metal fork on two separate occasions to threaten self harm, and although he/she required supervision with meals, the facility had no idea how or when he/she obtained them. Findings include: Review of the facility's policy, titled Accidents/Incidents, dated April 2015, indicated the following: -It is the responsibility of the staff to report all accidents and incidents which occur at the facility. -The charge nurse and/or the department director or supervisor must document the incident and conduct an investigation of the occurrence. -Every attempt will be made to ascertain the cause of the occurrence. Resident #1 was admitted to the Facility in March 2025, diagnoses included suicidal ideation, major depressive disorder, unspecified dementia, and delusional disorders. Review of Resident #1's Admission Minimum Data Set (MDS) assessment, dated 03/13/25, indicated the following: -He/she scored an 11 out of 15 on his/her Brief Interview for Mental Status (BIMS) assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests a resident is cognitively intact). -Had physical, verbal, and other behaviors for one to three days during the assessment period. -Had episodes of wandering for one to three days during the assessment period. -Could propel his/her wheelchair 150 feet in a corridor with supervision. Review of Resident #1's Dietary Care Plan, reviewed with the Admission MDS Assessment, included an intervention, dated as initiated 3/10/25, to provide plastic utensils with all meals. Review of Resident #1's Nursing Progress Note, dated 03/28/25, indicated he/she was found by staff to be in possession of a [metal] fork and was attempting to stab him/herself. The Note indicated Resident #1 was transferred to the Hospital Emergency Department (ED) for an evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at 1:51 P.M., Nurse #1 said she was on duty on 03/28/25 during the 7:00 A. M. - 3:00 P.M. (day shift) and Resident #1 was on her assignment. Nurse #1 said Resident #1 was weepy, and he/she pulled a metal fork, which had only one prong left, out from the side of his/her wheelchair and made the gesture of stabbing him/herself with it. Nurse #1 said Resident #1 was transferred to the Hospital ED for an evaluation. Review of Resident #1's medical record indicated he/she was readmitted to the facility on [DATE]. Review of Resident #1's Dementia Care Plan, initiated on 04/03/25, indicated Resident #1 had suicidal ideation's and suicide attempts, a new intervention for 1:1 monitoring by staff during meals was initiated on 04/11/25. Review of Resident #1's Nursing Progress Note, dated 05/08/25, indicated Resident #1 had taken a metal fork and broke off three of the four prongs and attempted to stab him/herself. The Note indicated Resident #1 was transferred to the Hospital ED for an evaluation and returned to the facility later that evening. During an interview on 05/21/25 at 1:51 P.M., Nurse #1 said she worked the day shift on 05/08/25. Nurse #1 said Resident #1 was found in his/her room with a metal fork, which had only one prong left, and made the gesture of stabbing him/herself in the chest. Nurse #1 said Resident #1 refused to tell her where he/she got the fork from. Nurse #1 said Resident #1 did not sustain any injury. Nurse #1 said Resident #1 was supposed to have only plastic ware and 1:1 staff supervision for all meals. On 05/21/25 at 8:02 A.M., the surveyor observed Resident #1 coming out of his/her room, propelling his/her wheelchair into the hallway. Resident #1 was able to independently self propel his/her wheelchair down the hallway to the unit dining room. During an interview on 05/21/25 at 9:00 A.M., Resident #1 said he/she did not want to be at the facility but added that he/she was not going to escape or anything like that. Although Resident #1's Care Plan interventions included that he/she was to be provided with plastic ware only for meals, that staff were to provide 1:1 supervision during meals, both of which were to prevent him/her from having access to metal utensils, Resident #1 was still able on two separate occasions, undetected by staff, to gain possession of and physically manipulate a metal fork, which he/she then in the presence of staff, used to threatened self harm. During an interview on 05/21/25 at 1:33 P.M., the Director of Nurses (DON) said she spoke with staff following the incident on 05/08/25 and a room search of Resident #1's room was conducted and nothing was found. The DON said she should have completed a full, written investigation following the incident on 05/08/25 and did not. The DON said that despite the interventions in Resident #1's care plan, he/she was able to obtain and manipulate silverware on two occasions.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was admitted to the facility with a history of suicidal ideation, self-injurious behavior, paranoia, and agitation, the facility failed to ensure behavioral psychiatric services evaluated him/her in a timely manner, following episodes of suicidal behaviors. Findings include: Review of the Facility's policy, titled Consultant Services, dated April 2015, indicated the Facility will identify and facilitate consultant services to meet the residents' needs, to ensure optimum care for each resident/patient through consultant services. Resident #1 was admitted to the Facility in March 2025, diagnoses included suicidal ideation, major depressive disorder, unspecified dementia, and delusional disorders. Review of Resident #1's Admission Minimum Data Set (MDS) assessment, dated 03/13/25, indicated he/she scored an 11 out of 15 on his/her Brief Interview for Mental Status (BIMS) assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests a resident is cognitively intact). The MDS also indicated Resident #1 had physical, verbal, and other behaviors for one to three days during the assessment period. Review of Resident #1's Behavioral Health Group Notes, dated 03/10/25 and 03/24/25, signed by Nurse Practitioner (NP) #1, indicated he/she had a history of suicidal ideation but was not a current risk to harm self or others. Review of Resident #1's Nursing Progress Note, dated 3/28/25, indicated staff found Resident #1 with a [metal] fork, trying to stab him/herself. Resident #1 was transferred to the Hospital Emergency Department (ED) for an evaluation. Review of Resident #1's Nursing Progress Note, dated 04/03/25, indicated Resident #1 was readmitted to the facility. Review of Resident #1's Nursing Progress Note, dated 04/05/25, indicated Resident #1 was observed with a plastic knife in his/her right hand and a [superficial] cut to his/her left forearm. The Note also indicated Resident #1 made continual suicidal ideation statements and was transferred to the Hospital ED for an evaluation. Review of Resident #1's Nursing Progress Note, dated 04/10/25, indicated Resident #1 was readmitted to the facility. Review of Resident #1's Nursing Progress Note, dated 04/11/25, indicated Resident #1 stated he/she wanted to kill him/herself. Resident #1 was transferred to the Hospital ED for an evaluation and returned to the facility later that day. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Behavioral Services Referral Log, used for facility staff to communicate to the Behavioral Services Group when a resident needs to be seen, indicated the following entries: -04/04/25- [Resident #1] presenting with SI [suicidal ideation]. -04/11/25- [Resident #1] transferred to the hospital ED for SI/depression. Further review of the Log indicated NP#1 initialed the entries (indicating she reviewed and was aware). Review of Resident #1's Behavioral Health Group Note, dated 04/24/25 and signed by NP #1, included the following: -Per nursing staff, the resident [has] decreased anxiety/depression, reports positive sleep/appetite, no SI. There is no current risk to harm self or others. -Plan/recommendations: continue to monitor and support as needed. No medication recommendations at this time. Review of Resident #1's medical record indicated that although behavioral psychiatric services were involved with his/her care, there was no documentation to support that their services were provided to Resident #1 until 04/24/25 (13 days after his/her most recent incident of suicidal behavior). Furthermore, there was no documentation to support that NP #1 identified or adjusted Resident #1's plan, despite his/her episodes of suicide ideation/behavior. Review of Resident #1's Nursing Progress Note, dated 05/08/25, indicated Resident #1 had taken a metal fork and broke off three of the four prongs and attempted to stab him/herself. The Note indicated Resident #1 was transferred to the Hospital ED for an evaluation and returned to the facility later that evening. During an interview on 05/21/25 at 12:59 P.M. and a telephone interview on 05/22/25 at 4:20 P.M., Nurse Practitioner (NP) #1 said that although she initialed the Behavioral Log entries on 04/04/25 and 04/11/25, she was unaware that Resident #1 had episodes of suicidal behaviors involving various utensils. NP #1 said the Behavioral Log had indicated suicidal ideation, but had not specified that Resident #1 had threatened to kill him/herself with a metal fork or that Resident #1 cut him/herself with a plastic knife. NP #1 said she was usually in the facility three days per week and that she may not have seen Resident #1 from 04/11/25 through 04/24/25 due to her case load. NP #1 said that the first time she was informed by nursing of a suicide attempt for Resident #1 was in relation to the incident that occurred on 05/08/25. NP #1 said once she was informed of Resident #1's suicidal behavior, she ordered for him/her to start Lithium (a mood stabilizer) daily. NP #1 said had she known of the previous suicidal behaviors she would have adjusted Resident #1's plan of care and/or medications earlier. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at 1:33 P.M., the Director of Nurses (DON) said she was not aware that Nurse Practitioner #1 was unaware of Resident #1's suicidal behaviors on 03/28/25 and 04/05/25. The DON said it was her understanding that NP #1 had been involved in Resident #1's plan of care since his/her admission to the facility.