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	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlborough Hills Rehabilitation & Health Care Cen	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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and records reviewed, for one of three sampled employee files (Director of Nurses #1), the Facility failed to ensure they implemented and followed their abuse policy related to pre-employment requirements and annual training when a Massachusetts Criminal Offender Record Information (CORI) check was not conducted on Director of Nurses #1, as required, prior to working at the Facility, and the facility was unable to provide documentation to support that DON #1 had received annual abuse prohibition training as required. Findings include: Review of the Facility Abuse, Neglect and Exploitation Policy, implemented February 2023, indicated that potential employees would be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. The Policy further indicated that background reference and credential checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. The Policy indicated the facility will maintain documentation of proof that the screening occurred.Further review of the Policy indicated that new employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. The Policy indicated existing staff will receive annual education through planned in-services and as needed. Review of Director of Nurses (DON) #1's Employee File, who served as the Acting Director of Nurses at the Facility beginning on 03/01/26 and who had been employed by the Corporation as a Regional Clinical Specialist since 01/17/19, there was no documentation to support that a CORI had been conducted prior to her employment, as required. Further review of the File indicated there was no documentation to support that DON #1 received training on abuse prohibition and reporting obligations at least annually. During an interview on 06/16/26 at 3:45 P.M., the Administrator said the Facility had no documentation to support that a CORI check had been conducted on DON #1 prior to hire. The Administrator said that CORI checks should be run on all employees prior to them working at the Facility. The Administrator further said there was no documentation to support that DON #1 had received annual training on abuse prohibition since her orientation as a new hire in January 2019.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on records reviewed and interviews, for one of three sampled residents (Resident #3), who on 6/06/26 alleged he/she had been physically abused by a staff member, the Facility failed to ensure that a summary of the results of the findings from their investigation into the 6/06/26 allegation was submitted to the Massachusetts Department of Public Health (DPH) within five working days, as required.Findings include:Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 06/06/26, indicated that Resident #3 alleged that he/she was kicked, punched and thrown to the ground by a staff member. Further review of HCFRS indicated that, as of the survey date (06/16/26), the Facility had not submitted a final summary of their findings from its investigation into the allegation of physical abuse involving Resident #3 that had been initially reported to DPH on 06/06/26, within five working days (was due by 6/12/26). During an interview on 06/16/26 at 3:45 P.M., the Administrator said they were unable to provide any documentation to support a summary of the Facility's investigative findings (into the 6/06/26 allegation) had been completed and submitted to the DPH within five working days (by 6/12/26) of the incident.