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	12/22/2023

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on policy review, record review and interview, the facility failed to ensure that one Resident (#43), out of a total sample of 33 residents, had the right to make healthcare decisions. Specifically, -For Resident #43, the facility failed to obtain written consent from, and provide education on the risks and benefits related to the use of an anti-psychotic (medication primarily used to manage psychosis) medication and an anti-depressant (medication used to treat depression) medication prior to administering psychotropic (any drug that affects behavior, mood, thoughts or perception) medication. Findings Include: Review of the facility policy titled Psychotropic Medication Informed Consent, revised February 2016, indicated the following: -Prior to administering psychotropic medication, the facility shall obtain the informed written consent of the resident. -Informed consent shall include the following information: purpose for administering the medication, the prescribed dosage, and any known effect or side effect of the psychotropic medication. -Documentation of informed consent for prescribing psychotropic medication including but not limited to, drugs that treat depression, anxiety disorder, or attention deficit/hyperactivity disorder. Resident #43 was admitted to the facility in October 2023 with diagnoses including Psychotic Disorder with Hallucinations (loss of reality with false, fixed beliefs, including the apparent perception of something that is not present), generalized Anxiety Disorder (severe, ongoing anxiety that interferes with daily activities), major Depressive Disorder (disorder characterized by persistently depressed mood and long term loss of pleasure or interest in life), and Schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). (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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	225063	A. Building B. Wing	12/22/2023

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had moderately impaired cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of total of 15, and no Health Care Proxy (HCP - legal document that designates a Resident Representative to make medical decisions) was invoked (Physician documentation of resident incapacity to make medical decision). Review of current Physcian's orders indicated: -Risperidone (anti-psychotic medication) 1 milligrams (mg)/milliliter (ml), give 3 ml/3 mg via J-tube (feeding tube) nightly, initiated 10/4/23 -Risperidone 1mg/ml, give 1.5 ml/(1.5 mg) via J-tube daily, initiated 10/4/23 -Sertraline (anti-depressant medication) 20mg/1 ml, give 10 ml (200mg) via J-tube daily, initiated 10/4/23 Review of the October 2023, November 2023, and December 2023 Medication Administration Records (MARs) indicated that Resident #43 received the medications daily as ordered from 10/4/23 - 12/22/23. Review of the clinical record did not show any evidence that a written Informed Consent for Psychotropic Administration was obtained and signed by Resident #43, and education on the risks and benefits on the use of Risperidone and Sertraline was provided before administration of the medications. The surveyor found a blank Psychotropic medication consent form that was flagged in the Resident's record. During an interview on 12/21/23 at 12:48 P.M., Nurse #5 said that any consents for medication would be obtained by the Nurse who completed the admission paperwork. Nurse #5 also said if the resident was self-responsible, then he/she would sign the Psychotropic Consent form. Nurse #5 further said that Resident #43 was self-responsible and made his/her own medical decisions. During an interview on 12/21/23 at 12:49 P.M., Social Worker (SW) #2 said that Resident #43 was his/her own responsible party. During an interview on 12/22/23 at 7:20 A.M., the Director of Nurses (DON) said that the Nurse completing the admission paperwork would also complete the Psychotropic Informed Consent forms if the resident was their own responsible person. The DON said if the resident was self-responsible, staff would immediately go to the resident and explain the psychotropic consent, including risks and benefits of the psychotropic medications. The DON then gave the surveyor informed consents for Risperidone and Sertraline signed by Resident #43, that were dated 12/22/23, and said that she obtained the consents from the Resident that morning.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on record review and interview, the facility failed to include one Resident (#43) out of a total sample of 33 residents, in the care planning process. Specifically, the facility staff was unable to provide evidence of a care plan meeting for Resident #43, and that he/she had been invited to and/or participated in a care plan meeting as required. Findings Include: Resident #43 was admitted to the facility in October 2023. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had moderately impaired cognition as evidenced by Brief Interview for Mental Status (BIMS) score of 10 out of 15, and no Health Care Proxy (HCP- legal document that designates a Resident Representative to make medical decisions) was invoked (Physician documentation of resident incapacity to make medical decision). During an interview on 12/19/23 at 8:40 A.M., the Resident said that he/she had not participated in any care plan meetings and did not recall being invited to any care plan meetings since he/she was admitted to the facility in October 2023. Further review of the medical record indicated no evidence of a care plan meeting being held after Resident #43's admission to the facility in October 2023 and relative to the comprehensive MDS assessment on 10/9/23. During an interview on 12/20/23 at 2:53 P.M., Social Worker (SW) #2 said when care plan meetings are held, there is a physical sign-in sheet for the Resident, Resident Representative, and interdisciplinary team (IDT) and staff will complete a progress note regarding the meeting. During a follow-up interview on 12/20/23 at 3:54 P.M., SW #2 said that Resident #43 was not invited to any care plan meetings nor were any care plan meetings held with the IDT since his/her admission to the facility in October 2023. SW#2 further said that the Resident should have had a care plan meeting relative to the 10/9/23 MDS assessment and a care plan meeting was not held as required.

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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** 45429 Based on observation, interview, policy and record review, the facility failed to implement a care plan for one Resident (#87) out of a total sample of 33 residents. Specifically, the facility staff failed to ensure that Resident #87's left palm guard was applied daily as ordered for contracture prevention, prevent skin breakdown and to increase range of motion (ROM). Findings include: Review of the facility policy for Splints/Orthotics/Prosthetics, last revised April 2015, indicated: -nursing staff will apply/remove the designated splint/orthotic/prosthetic device during scheduled wearing times. -nursing staff should notify the rehabilitation department of any .misplaced splint/orthotic/prosthetic device. -devices are to be labeled with the resident's name and maintained in a safe place when not in use. Resident #87 was admitted to the facility in October 2022 with diagnoses including Multiple Sclerosis (auto-immune disease that destroys the nerves and causes communication problems between the brain and the rest of the body) and muscle weakness. Review of Resident #87's Physician's orders for December 2023 included: -orders dated 6/1/23 for a left palm guard. -don left palm guard with finger separators with morning care and doff (remove) with evening care for prevention of skin breakdown and contracture management. Review of Resident #87's care plan for Activities of Living (ADL's) last revised 8/7/23, indicated: -the Resident demonstrates a decreased ability to perform ADL's due to activity tolerance, balance, endurance, pain, range of motion impairments, strength. -the Resident requires assistance of 1-2 people for ADLs -nursing staff to don (put on) left hand orthotic (palm guard) with morning care and [sic] evening care daily for contracture prevention, preventing skin breakdown and increase range of motion. (continued on next page)

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	225063	A. Building B. Wing	12/22/2023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #87's Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The MDS also indicated that the Resident had a physical impairment on one side and had been receiving Occupational Therapy (OT- teaching focused on how to adapt at home, work or school often using assistive devices) services. On 12/19/23 at 9:00 A.M., the surveyor observed Resident #87 lying in bed. The surveyor did not observe the left palm guard on his/her left hand as ordered. On 12/20/23 at 10:45 A.M., the surveyor observed Resident #87 lying in bed. The surveyor did not observe the Resident to have the left palm guard on as ordered. During an interview at the time, Resident #87 said that he/she had not used the palm guard since he/she had been on therapy approximately one month prior. On 12/20/23 at 3:47 P.M., the surveyor observed Resident #87 in a wheelchair sitting outside the building in a group recreation area. The surveyor did not observe the left palm guard on his/her left hand, and he/she said that they were concerned because the left hand was curling back up again, and he/she feared that the facility had lost the palm guard. During an interview on 12/21/23 at 8:09 A.M., CNA #2 said that she was unaware that Resident #87 had a palm guard to wear on his/her left hand. During an interview on 12/21/23 at 8:11 A.M., Nurse #3 said that she could not recall the last time Resident #87 had worn the left palm guard. The surveyor and Nurse #3 observed Resident #87 lying in bed, and the left palm guard was not on the Resident's left hand as ordered. Nurse #3 was not able to locate the left palm guard in the Resident's room and said that she would contact the rehabilitation department to obtain a new one. See F842

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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** 48206 Based on observations, record review and interviews, the facility failed to provide or arrange for care and services that accepted standards of quality dictate should have been provided for one Resident (#43) out of a total sample of 33 residents. Specifically, the facility staff failed to ensure that Resident #43 was weighed weekly as ordered by the Physician and recommended by the Registered Dietitian (RD) post hospitalization and Jejunostomy tube (J-tube- tube placed through the skin of the abdomen into the midsection of the small intestine to deliver food and medicine) placement, which resulted in delayed identification of a significant weight loss for the Resident. Findings include: Review of the facility policy titled Weights, dated August 2015, indicated that Residents are weighed weekly, times four weeks for the following: -A newly admitted resident, with a new feeding tube, and -Residents with a Physician order for weekly weights. -Thereafter, residents will be weighed monthly unless clinically indicated. -Weights are to be documented in the Resident's medical record. -If a significant weight loss is identified (greater than 5% loss in 30 days or greater than 10% loss in 6 months), the Interdisciplinary Team (IDT), Dietician, Physician, and family are notified. Resident #43 was admitted to the facility in October 2023 with diagnoses including artificial openings of gastrointestinal tract (Jejunostomy tube/J-tube- tube placed through the skin of the abdomen into the midsection of the small intestine to deliver food and medicine), Dysphagia (difficulty swallowing), and moderate protein-calorie malnutrition (a deficiency, excess, or imbalance in nutrient intake). Review of the History and Physical, dated 10/4/23, indicated the following: -During hospitalization from [DATE] -10/3/23, Resident #43 had poor intake by mouth and failed multiple Speech Language Pathology (SLP) evaluations, had a Modified Barium Swallow (MBS- procedure to determine whether food or liquid is entering the lungs) with evidence of aspiration (when food, liquid or other materials enter the airway and eventually the lungs by accident) with all food textures, requiring placement of a J-tube for enteral (method of nutrition delivered directly to the gastrointestinal tract) access. -Diagnosis of moderate protein-calorie malnutrition as evidenced by decline in weight. (continued on next page)

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	225063	A. Building B. Wing	12/22/2023

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Recommendation for plan of care to monitor weights as ordered by Physician. -Goal for the Resident to maintain his/her current weight, plus/minus 4 pounds from their baseline weight. Review of the Nutrition Evaluation, dated 10/4/23, indicated Resident #43 received all nutrition and hydration via J-tube and did not take any food or drink by mouth due to Dysphagia. The RD recommended a diagnosis of Risk of Malnutrition be added to the record and weight order for weekly weights for four weeks, and then monthly. Review of the Minimum Data Set Assessment (MDS) dated [DATE], indicated that Resident #43 had moderately impaired cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15, had a feeding tube in place, and received his/her calories via tube feed for nutrition and also received hydration via tube feed. Review of the October 2023 Physician's orders indicated the following: -Jevity 1.5 at 55 milliliters (mls) per hour, continuous, initiated 10/3/23 -Flush with 60 mls per hour, continuous, initiated 10/3/23 -Diet: Nothing by mouth, tube feeding only, initiated 10/3/23 -Weigh weekly on Tuesdays on 7:00 A.M.- 3:00 P.M. (Day) shift for four weeks upon admission, initiated 10/3/23 Review of the clinical record indicated Resident #43's weight was obtained via a mechanical lift scale on 10/4/23 and his/her weight was 159.8 pounds. Review of the October 2023 Treatment Administration Record (TAR) did not indicate documented evidence that the Resident's weights were obtained as ordered by the Physician on the following Tuesday's: 10/10/23, 10/17/23, 10/24/23, and 10/31/23. Review of the November 2023 Physician's orders indicated the following: -Weight monthly on the 1st Wednesday, initiated 10/31/23. - Jevity 1.5 milliters (ml) at 65 ml per hour (hr) for 20 hours, initiated 11/29/23 -Water flush 60 ml per hour for 20 hours, initiated 11/29/23 Review of the November 2023 TAR failed to provide evidence that a weight was obtained on the 1st Wednesday of the month: 11/1/23. Review of the clinical record indicated Resident #43's weight was obtained via a mechanical lift scale on 11/29/23 and his/her weight was documented as 132.4 pounds (decrease of 27.4 pounds from the 10/4/23 weight). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the RD Progress Note dated 11/29/23, indicated Resident #43 experienced a significant weight loss of 17.51% at 132.4 pounds since the last recorded weight on 10/4/23 of 159.8 pounds. The RD recommended weekly weights be obtained. Review of Resident #43's Nutrition Care Plan revised 11/29/23, indicated: -Monitor and evaluate weight and weight changes -Notify RD, family, and Physician of significant weight changes -Obtain weights (weekly for four weeks then monthly as ordered) and record Review of Resident #43's Tube Feeding Care Plan revised 11/29/23, indicated the Resident was dependent on tube feeding as ordered via a J-Tube as his/her current nutrition source due to Dysphagia and included the following interventions initiated on 10/4/23: -Monitor the Resident's body weight and labs as needed -Weekly weights for four weeks then monthly as ordered During an observation and interview on 12/19/23 at 8:40 A.M., the surveyor observed Resident #43 lying in bed with Jevity 1.5 running at 65 ml/hr and water flush running at 60 ml/hr, both dated 12/19/23, as ordered by the Physician. The Resident said he/she was aware of the tube feeding and had been receiving the tube feeds for several weeks. During an interview on 12/22/23 at 7:31 A.M., the RD said Resident #43 had a lengthy hospitalization with a new insertion of a J-tube for enteral nutrition prior to re-admission to the facility in October 2023. The RD said the Resident had a history of significant weight loss while in the facility prior to the hospitalization . The RD further said that she uses the Resident's weights to calculate nutritional and hydration needs for the tube feeding. During a follow-up interview on 12/22/23 at 11:35 A.M., the RD said that residents returning from the hospital are weighed weekly for four weeks and then monthly if the weights are stable. The RD said that she was not aware that Resident #43 did not have additional weights obtained after 10/4/23, as ordered by the Physician, until she ran her weight report for the month of November on 11/29/23. The RD further said that Resident #43 was not weighed weekly as ordered by the Physician from 10/5/23 through 11/28/23.

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	12/22/2023

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47901 Based on observation and interview, the facility failed to ensure that pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) were available to meet the needs of each resident. Specifically, the facility failed to ensure: -that emergency medication kits (E-Kits) were re-ordered and replaced by the Pharmacy after being opened. -that appropriate documentation was completed as required for medications removed from the E-Kits. Findings include: On 12/20/23 at 10:50 A.M., the surveyor and Nurse #2 observed the First Floor [NAME] Wing Medication Storage Room and identified the following: a. Intravenous (IV) Kit was opened with no paper documentation indicating what was removed from the kit and for which resident. b. An emergency kit Super Kit (a kit that had most of the facility's used medications for the residents, example blood pressure medications) was laying directly on the floor in the Medication Storage Room. The Super Kit contained a paper that itemized all the medications that should have been included in the kit. Nurse #2 reviewed the contents of the kit and said that four Lopressor (medication to treat high blood pressure) tablets had been removed, and there was no indication of the date the medication was removed, which resident the medication was administered to, the name of the Nurse that removed the medication, and whether the kit had been re-ordered from the Pharmacy. c. Coumadin (blood thinning medication) kit was opened. d. Anaphylactic (allergy) kit was opened, Kayexalate (medication used to treat elevated potassium levels in the blood) had been removed. e. Insulin kit was opened and a paper list indicated the following missing items were removed from the kit: -1 Basaglar (a long-acting basal insulin used to control high blood sugar in adults) Insulin Pen -1 Humalog (a fast-acting insulin used to treat high blood sugar) Insulin Pen -1 Admelog (a fast-acting prescription human insulin used to help control blood sugar levels) Insulin Pen -1 Lispro (a short-acting man-made insulin used to treat high blood glucose levels) Insulin Pen. (continued on next page)

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	225063	A. Building B. Wing	12/22/2023

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no indication on what date the insulin kit was opened, when each individual pen was removed from the kit, which staff removed the insulin pens, which resident the medications were removed for, and if the Insulin kit had been re-ordered. During an interview at the time, Nurse #2 said that whenever the emergency kit was opened, the Nurse must fill out a form that indicates the medication that was removed from the kit, the resident's name, the date, and time the medication was removed, and the name of the Nurse who removed the medication. The form must then be faxed to the Pharmacy and the replacement kit would typically be delivered to the facility by the Pharmacy later that same day. Nurse #2 said that the emergency kits on the First Floor [NAME] Wing were the only emergency medication kits in the facility and that the E-Kits contained medications not available on the other units at the facility. Nurse #2 also said that there was no evidence that the form was faxed to the Pharmacy by the Nurse who opened the Super Kit, the IV Kit, the Coumadin Kit, the Anaphylactic Kit and the Insulin Kit. The facility staff could not provide a policy for the management of the E-kits when the surveyor requested the policy. During an interview on 12/20/23 at 11:45 A.M., Nurse #2 said she did not know when the emergency kits (found during the observation) were opened, which Resident (s) the medications from the E-kits were administered to, which Nurse (s) opened the E-kits and whether the opened E-kits had been re-ordered from the Pharmacy.

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	225063	A. Building B. Wing	12/22/2023

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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. 44337 Based on observation and interview, the facility failed to store medications in a safe, and secure manner as required. Specifically, the facility staff failed to secure the medication Escitalopram (a psychotropic medication used to treat Depression) in a secure manner after the medication was delivered from the Pharmacy. Findings include: Per S483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. On 12/21/2023 at 9:17 A.M., the surveyor observed two blister pack medication cards, each containing thirty tablets of Escitalopram (a psychotropic medication used to treat Depression) laying unsecured on a desk, behind the nurses station on the East Wing. During an interview on 12/21/2023 at 9:20 A.M., Unit Manager (UM) #1 said that the medication observed by the surveyor on the nurses station desk had been delivered from the Pharmacy at 4:00 A.M., and that the medication belonged to a resident who had moved to a different nursing unit. UM #1 said if the Pharmacy delivers medication to the wrong nursing unit then it is the responsibility of the Nurse to take the medication to the correct nursing unit. UM #1 also said that it was not safe to have the medications laying out in the open, on the nurses station desk because any resident or visitor could have walked by and picked up the medication. UM #1 further said that she should have locked the medication in the medication room until she had a chance to take it to the other nursing unit where the resident was transferred.

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	225063	A. Building B. Wing	12/22/2023

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, record and policy review, the facility failed to maintain accurate documentation for two Residents (#87 and #26) out of 33 residents sampled. Specifically: 1. For Resident #87, the facility staff erroneously documented that a left palm guard was being applied when the device had been misplaced and was not being used by the Resident. 2. For Resident #26, the facility staff failed to maintain accurate records related to Advanced Directive planning for the Resident. Findings include: Review of the facility policy for Splints/Orthotics/Prosthetics last revised [DATE], indicated: -nursing staff will apply/remove the designated splint/orthotic/prosthetic device during scheduled wearing times. -nursing staff should notify the rehabilitation department of any .misplaced splint/orthotic/prosthetic device. -devices are to be labeled with the resident's name and maintained in a safe place when not in use. 1. Resident #87 was admitted to the facility in [DATE] with diagnoses including Multiple Sclerosis (auto-immune disease that that destroys the nerves and causes communication problems between the brain and the rest of the body) and muscle weakness. Review of Resident #87's care plan for Activities of Living (ADL's) last revised [DATE], indicated: -the Resident demonstrates a decreased ability to perform ADL's due to activity tolerance, balance, endurance, pain, range of motion impairments, strength. -the Resident requires assistance of ,d+[DATE] people for ADLs -nursing staff to don left hand orthotic (palm guard) with morning care and [sic] evening care daily for contracture prevention, preventing skin breakdown and increase range of motion. Review of Resident #87's Minimum Data Set (MDS) assessment dated [DATE] indicated that the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The MDS also indicated that the Resident had a physical impairment on one side and had been receiving Occupational Therapy (teaching focused on how to adapt at home, work or school often using assistive devices) services. (continued on next page)

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	12/22/2023

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #87's Physician's orders for [DATE] included orders dated [DATE], for a left palm guard: don with finger separators with morning care and doff with evening care for prevention of skin breakdown and contracture management. Review of Resident #87's Treatment Administration Record (TAR) for [DATE], indicated that the Resident had his/her left palm guard applied (put on and taken off) as ordered for the documentation period of [DATE] to [DATE]. On [DATE] at 9:00 A.M., the surveyor observed Resident #87 lying in bed. The Resident did not have the left palm guard on his/her left hand as ordered. On [DATE] at 10:45 A.M., the surveyor observed Resident #87 lying in bed. The Resident was not observed to have the left palm guard applied on his/her left hand as ordered. During an interview at the time, Resident #87 said he/she had not used the left palm guard since he/she had been receiving therapy approximately one month prior ([DATE]). On [DATE] at 3:47 P.M., the surveyor observed Resident #87 in a wheelchair sitting outside the building in a group recreation area. The Resident was not observed to be wearing the left palm guard on his/her left hand. During an interview at the time, the Resident said that he/she was concerned because his/her left hand was curling back up again, and he/she feared that the facility had lost the left palm guard. During an interview on [DATE] at 8:09 A.M., CNA #2 said that she was unaware that Resident #87 had a palm guard to wear on his/her left hand. During an interview on [DATE] at 8:11 A.M., Nurse #3 said that she could not recall the last time Resident #87 had worn the left palm guard. the surveyor and Nurse #3 reviewed the [DATE] TAR, and she said that she had not completed the TAR sheets correctly. Nurse #3 further said that she had been marking off that Resident #87 had been wearing the left palm guard when he/she had not been wearing the device. 44337 2. Resident #26 was admitted to the facility in [DATE] with diagnoses of Mild Neurocognitive Disorder, Cognitive Communication Disorder, End Stage Renal Disease (a condition in which the kidneys no longer function properly to remove toxins and waste from the blood) and Diabetes Mellitus Type II (chronic condition where the body is unable to regulate blood sugars and results in high levels of sugar in the blood). Review of the facility policy titled Medical Orders for Life Sustaining Treatment (MOLST) dated [DATE] indicated the following: -The MOLST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference . -A fully executed, dated copy of the MOLST, marked copy should be retained in the medical record in the advance directive section of the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the instructions for completing the MOLST form indicated that if any section of the form is not completed, then there is no limitation on the treatment indicated in that section. Review of Resident #26's care plan, initiated [DATE] and revised [DATE], indicated that the Resident had an established Advanced Directive, follow MOLST. Further review of the care plan indicated the following interventions initiated [DATE]: -Do not administer CPR -Review Advanced Directives with resident and/or HCP quarterly. During an interview on [DATE] at 10:33 A.M., Unit Manager (UM)#1 said that Resident 26's MOLST form had not been completed by his/her HCP, and if a MOLST form is not filled out and signed by the HCP then the resident is considered a Full Code (receive all resuscitation procedures). She further said that the current signed Physician order indicated that Resident #26 was a DNR/DNI. During a review of the clinical record at that time, UM#1 said that she could not provide any evidence that the Resident's Advanced Directive status, should have been DNR/DNI. She said the Resident is a Full Code because the MOLST form had not been filled out and signed by the Resident's HCP.