STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075232	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobalt Lodge Health Care and Rehabilitation Center	29 Middle Haddam Rd Cobalt, CT 06414

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 0600 Level of Harm - Minimal harm or potential for 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 review of the clinical record, facility documentation, facility policies, and interviews for 2 of 3 (Residents #39 and 45) reviewed for abuse, the facility failed to ensure that Resident #39 was free from physical abuse by another resident, and that Resident #45 was free from sexual abuse by another resident. The findings include: 1a. Resident #39 was admitted to the facility in April 2022 with diagnoses that included mild unspecified dementia without behavioral disturbances, adjustment disorder, and mild cognitive impairment of unknown etiology. The annual MDS dated [DATE] identified Resident #39 had intact cognition and had not exhibited physical behaviors directed towards others (e.g. hitting, kicking, pushing, scratching, or abusing others sexually), verbal behaviors directed towards others (threatening, screaming, or cursing), or other behavioral symptoms not directed towards others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, screaming, or disruptive sounds), and was independent with walking 150 feet. The care plan dated 2/24/26 identified Resident #39 was at risk for a behavior problem of accusatory comments related to dementia. Triggers for accusatory behaviors included another resident in the facility with the resident's behavior de-escalated by redirection and separation. The care plan further identified that Resident #39 had impaired cognitive function/dementia or impaired thought processes related to dementia, with interventions that included cueing, reorienting, and supervising as needed. b. Resident #70 was admitted to the facility in September 2025 with diagnoses that included severe dementia with agitation, delirium due to a known physiological condition, and adjustment disorder with mixed anxiety and depressed mood. (Resident #70 no longer resides at the facility). The quarterly MDS dated [DATE] identified Resident #70 had severely impaired cognition, had not exhibited physical behaviors directed towards others, verbal behaviors directed towards others, or other behavioral symptoms not directed towards others, and required setup assistance with wheeling 50 feet with two turns in a manual wheelchair. The care plan dated 1/5/26 identified Resident #70 had impaired cognitive function/dementia or impaired thought processes related to dementia, with interventions that included cueing, reorienting, and supervising as needed. The care plan further identified that Resident #70 had the potential to be physically aggressive related to dementia and poor impulse control, with interventions that included, when resident becomes agitated: intervening before agitation escalates, guiding away from source of distress, engaging calmly in conversation, and analyzing the times of day, places, circumstances, triggers, and what deescalates the behaviors and document. The Reportable Event Form dated 3/11/26 identified that on 3/11/26 at 3:04 PM Resident #39 had an altercation in the recreation room and was struck in the face by another resident. The incident was witnessed by a family member visiting an un-involved resident. The nurse's note dated 3/11/26 at 3:35 PM identified that Resident #39 was in the recreation room during a karaoke program, one witness stated that another resident struck Resident #39 in the mouth. The residents were immediately separated and removed from the recreation room. Resident #39 was assessed for physical injury, and no physical injury or acute distress was identified related to incident. When asking Resident #39 about the events leading up to the incident, Resident #39 stated that Resident (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#70 was tucking in a blanket of another resident, and when Resident #39 told Resident #70 to leave the other resident alone, Resident #70 stated, don't tell me what to do, and then struck Resident #39 in the mouth. Resident #39 was offered to speak with the Psychiatric PA via telehealth and politely declined stating and indicated he/she was fine. The local Police Department, the physician, and the Administrator were notified; Resident #39 declined to have the resident representative notified as the resident was alert and oriented and able to make informed decisions. The Psychiatric Evaluation and Consultation dated 3/11/26 identified Resident #39 was involved in an altercation involving another resident, who punched him/her. Resident #39 was being protective over another resident, when the resident who punched him/her was trying to adjust a blanket on the other resident, who is often cold. Resident #39 did not want to talk to anyone about the incident The nurse's note dated 3/11/26 at 3:35 PM identified Resident #70 was observed in the recreation room during a group activity, and a witness reported that Resident #70 struck another resident in the face. Staff responded immediately and the residents were separated to prevent further contact. Resident #70 was removed from the area and placed under 1:1 observation for safety, pending a psychiatric evaluation. Resident #70 was assessed, and no acute distress was noted. When asked what occurred, Resident #70 stated, I don't know, I want to go back to karaoke. Resident #70 was informed that he/she was observed striking another resident. Resident #70 responded that the resident told me to punch him/her. Resident #70 was assessed for safety, and when asked if he/she had any intent or plan to harm him/herself or anyone else, Resident #70 denied suicidal or homicidal ideation (SI/HI). Resident #70 was asked permission to participate in a telehealth psychiatric evaluation with the facility's Psychiatric PA; he/she was agreeable. The Psychiatric Evaluation and Consultation dated 3/11/26 identified Resident #70 was seen urgently via telehealth following a resident-to-resident incident. It was reported that Resident #70 told another resident to shut up and when he/she did not, he/she hit him/her in the shoulder. In collaboration with the Nursing Supervisor and Assistant Director of Nursing, it was identified that a family member of a resident saw Resident #39 reprimand Resident #70 telling him/her to stay away from another resident. Once Resident #70 did not listen and continued to move a blanket covering the other resident in a gesture of help, Resident #39 pointed his/her finger and said, leave him/her alone, at which point, Resident #70 punched Resident #39 in the face. No complaints were noted initially from Resident #70. Once Resident #70 was asked about the argument, he/she stated that someone told him/her to hit Resident #39 (whose name he/she was not able to recall). Resident #70 said after he/she did it, he/she was blamed for it, and reported that he/she was tired of these groups playing tricks for fun, always accusing him/her, and he/she was the one getting in trouble all the time. This was a witnessed incident, where it was seen that Resident #70 punched another resident who reprimanded him/her to stop touching another resident. Resident #70 proceeded to fix another resident's blanket when Resident #39 came over and pointed a finger at him/her and told him/her to stop at which point Resident #70 punched Resident #39. Resident #70 had no recollection of the actual incident or who was involved and does not appear to be a harm to him/herself or anyone else. The facility may continue or discontinue monitoring of the patient based on their own policies. No signs and symptoms of SI/HI. Interview with LPN #2 on 6/1/26 at 3:09 PM identified that she was the Charge Nurse on 3/11/26 and could recall the incident between Residents #39 and 70 but did not witness the event. LPN #2 identified that she was working on the medication cart when the Recreation Director came out and notified her that Resident #70 had hit Resident #39; and when she assessed Resident #39, he/she denied pain and there were no marks on his/her skin. LPN #2 indicated that Resident #70 had another resident-to-resident altercation, but she could not recall which incident had occurred first. Interview with Resident #39 on 6/1/26 at 4:26 PM identified that she could recall the 3/11/26 incident very well; Resident #70 was wrapping a blanket around another resident's neck, and the other resident was getting hot, so he/she went over to get the blanket off of the other resident because the room was so hot with the heat turned on, and then Resident #70 closed fist hit him/her in the lip. Resident #39 identified that his/her lip was swollen, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but he/she did not want help from any of the facility staff, as he/she dealt with it. Interview with the Recreation Director on 6/1/26 at 4:33 PM identified that Resident #70 had very advanced dementia, and while Resident #70 had gotten into a few verbal altercations with other residents because he/she would try to tell people what to do, but he could not recall hearing of or witnessing any physical altercations, prior to the 3/11/26 incident. The Recreation Director indicated that he was across the room when he heard a commotion, and when he got to the area of the incident, there was still a lot of anger there and Resident #70 had his/her fist in front of Resident #39. The Recreation Director indicated he did not see any physical contact between the 2 residents but did calm them both down and separate them. Interview with the DNS on 6/2/26 at 2:46 PM identified that it was her expectation that residents were free from abuse, and that it was the facility's job to keep residents safe. The DNS identified that following the incident Resident #39 had declined visits from the Psychiatric PA and refused to allow facility nurses complete a thorough assessment of the lip, and once Resident #70 was cleared from 1:1 observation and met with the Psychiatric PA, he/she remained on nursing checks every 15-minutes until he/she was discharged from the facility. 2a. Resident #45 was admitted to the facility in September 2019 with diagnoses that included paranoid schizophrenia and bipolar 2 disorder. The quarterly MDS dated [DATE] identified Resident #45 had severely impaired cognition, had not exhibited physical behaviors directed towards others, verbal behaviors directed towards others or other behavioral symptoms not directed towards others, and was dependent on staff assistance for rolling left to right, sitting to lying, and sitting to standing. The care plan dated 2/23/26 identified Resident #45 had an ADL self-care performance and mobility deficit related to limited mobility, behavioral symptoms, and cognitive impairment, with interventions that included getting Resident #45 out of bed after morning care to wheelchair with pelvic positioning belt and headrest per the 24-hour positioning plan. The care plan further identified that Resident #45 had impaired cognitive function/dementia or impaired thought processes related to diagnosis of dementia, with interventions that included engaging Resident #45 in simple, structured activities that avoid overly demanding tasks. b. Resident #18 was admitted to the facility in September 2025 with diagnoses that included unspecified dementia without behavioral disturbances and major depressive disorder. The quarterly MDS dated [DATE] identified Resident #18 had severely impaired cognition, had not exhibited physical behaviors directed towards others, verbal behaviors directed towards others, or other behavioral symptoms not directed towards others, and required supervision or touching assistance with wheeling 50 feet with two turns in a manual wheelchair and wheeling 150 feet in a manual wheelchair. The care plan dated 1/15/26 identified Resident #18 was an elopement risk/wanderer, had impaired safety awareness, and wanders aimlessly, with interventions that included de-escalating behaviors with redirection and distracting him/her from wandering by offering pleasant diversions, structured activities, food, and conversation. The care plan further identified Resident #18 had impaired cognitive function/dementia or impaired thought processes related to dementia, with interventions that included cueing, reorienting, and supervising, as needed. The Reportable Event Form dated 3/13/26 identified that on 3/13/26 at 2:45 PM, Resident #18 was observed inappropriately touching another resident, in the Wing 2 hallway. The nurse's note dated 3/13/26 at 4:33 PM identified that the nursing staff reported an observation of Resident #18 inappropriately touching another resident. Resident #18 was immediately removed from the area and put on 1:1 supervision, pending a psychiatric telehealth visit. Resident #18 was alert and confused. Resident #18 was unable to recall the details of the incident and was cooperative with staff. The Administrator, physician, and the responsible party were notified; behavioral monitoring remains in place, and staff were aware of increased supervision in common areas. The nurse's note dated 3/13/26 at 4:35 PM identified that nursing staff reported an observation of another resident inappropriately touching Resident #45 in the hallway, which was witnessed by the Charge Nurse, on the unit. Both residents were immediately separated, and a physical assessment was completed, with no injury. Resident #45 denied pain/discomfort, no facial grimacing or guarding present was present. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45 was unable to recall details of the incident. The Administrator, physician, and responsible party were notified. Psychiatric consult was placed for follow-up; increased supervision in common areas was implemented by nursing staff and a report was filed with the state agency, per protocol. The Psychiatric Evaluation and Consultation dated 3/13/26 identified, in part, that Resident #18 was seen urgently via telehealth after a video captured him/her groping another resident seated in a wheelchair. Resident #18 was seen in his/her room and was cooperative with answering questions, but was at times sarcastic and dismissive, with no recollection of touching another resident. Once asked about inappropriately touching someone, Resident #18 became angry and denied doing such a thing and stated that he/she would never do that to anyone. Of note, as reported in previous psychiatric notes, Resident #18 had been inappropriate at times with staff and other residents. Each time due to his/her dementia, he/she forgets. Resident #18 has no recollection of the incident or who was involved; we have increased his/her medication with the hopes of mitigating his/her over sexualized energy. Resident #18 did not appear to a harm to him/herself or others. The facility may continue or discontinue monitoring of Resident #18 based on their own policies. We may consider an antipsychotic medication for this repeated behavior. Interview with the Charge Nurse (LPN #3) on 6/1/26 at 3:22 PM identified that Resident #18 had been known to have inappropriate language on occasion, like inviting people to sit on his/her lap, but she had never observed nor was she aware of any prior incidents of inappropriate touching or other any other type of sexual behaviors directed toward staff or other residents. LPN #3 indicated that Resident #18 was able to self-propel in his/her wheelchair, and that on 3/13/26 she had stepped away from the nurse's station for no more than 5 minutes; when she returned she observed Resident #18 wheelchair close to Resident #45's wheelchair, and Resident #18 was fondling Resident #45's left breast with his/her right hand. LPN #3 indicated that while Resident #45 was awake during the incident, he/she did not appear to be having a reaction one way or another; LPN #3 separated Resident #18 and #45 and reported the incident immediately to the DNS. Interview with the Nursing Supervisor (RN #3) on 6/1/26 at 4:22 PM identified that she did not observe the incident that took place on 3/13/26 between Residents #18 and 45, but she was with Resident #18 during the telehealth visit with the Psychiatric APRN following the incident, and that during the telehealth visit, Resident #18 could not recall the event. Interview with the DNS on 6/2/26 at 2:46 PM identified that it was her expectation that residents were free from abuse, and that it was their job to keep residents safe. The DNS further identified that they do have a large dementia population at the facility, and following the 2 reportable events that were close together (3/11/26 and 3/13/26), the facility invited Supportive Care Services to provide staff reeducation on how to manage dementia related behaviors. The DNS further indicated that Supportive Care has been invited to provide additional in-services to the facility staff related to managing care for dementia residents. The DNS identified that Resident #18 remained on nursing checks every 15-minutes and that he/she was care planned to have supervision while in common areas and to be redirected if he/she was in close proximity to Resident #45 or any other vulnerable residents. The facility's Resident Rights policy directs the facility to follow and adhere to the Resident [NAME] of Rights. The [NAME] of Rights is given to staff, residents, and families to ensure compliance. At a minimum, federal law specifies that nursing homes must protect and promote the rights of each resident. Residents have the right to be free from abuse and neglect, including verbal, sexual physical, and mental abuse. The facility's Abuse and Neglect policy directs that residents have the right to be free from abuse, corporal punishment, involuntary seclusion, and psychosocial harm. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The types of abuse include verbal abuse, sexual abuse, physical abuse, mental abuse, and voluntary seclusion, and psychosocial harm.