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	01/07/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to ensure that a cognitively impaired resident who had wandering behaviors that included wandering into other resident's rooms, and laying in other residents beds had interventions in place to ensure the resident was free from sexual abuse. The failures resulted in a finding of Immediate Jeopardy. The findings include: 1. Resident #2 had diagnoses including vascular dementia with anxiety, major depressive disorder and post-traumatic stress disorder. A care plan dated 11/6/24 identified that the resident had a behavior problem because of using sexual language at times with interventions that directed to encourage the resident to express feelings appropriately, monitor behavioral episodes and determine underlying cause, administer medications as ordered, and psychiatric consults as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of ten (10) indicative of moderately impaired cognition and was independent with bed mobility and transfers and utilized a wheelchair independently for mobility. 2. Resident #1 had diagnoses including dementia with agitation, anxiety and restlessness with agitation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and was independent with ambulation. Review of an undated facility face sheet identified Person #1 as the resident's next of kin and health care proxy (court appointed to make health care decisions). (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The Resident Care Plan (RCP) dated 11/6/24 identified that Resident #2 was at risk for wandering and entering other resident's rooms and lying in other resident's beds due to a diagnosis of dementia with interventions to distract the resident by providing diversional activities, and a wander alert bracelet (a bracelet worn to alert staff when the resident is near an exit). The care plan further identified that the resident hugs, strokes hands and arms and kisses staff and other residents with interventions that included medications as ordered, provide baby doll to hold, encourage the resident to express feelings, and if attempts to kiss other male residents, redirect. Review of the facility Reportable Event (RE) dated 12/14/24 identified that Resident #1 was observed in Resident #2's bed, under the covers. The nurse removed the covers and noted that Resident #1 did not have his/her brief on, and his/her gown was pulled up to the chest. Resident #2's hand was noted between Resident #1's legs just above his/her knees, and Resident #2 quickly removed his/her hand once uncovered. The residents were separated, Resident #1 was placed on every fifteen (15) minute checks, Resident #2 was placed on one-to-one staff observation. The RE further identified that Resident #1 reported no pain, and a body audit was completed with no injuries noted. The RE summary identified that Resident #1 has severe A psychiatric Advanced Practice Registered Nurse (APRN) note dated 12/15/24 at 6:15 PM identified Resident #1 was involved in a resident-to-resident inappropriate interaction. Recommendations included continuing every fifteen (15) minute checks due to potential wandering into other residents' rooms which may increase the risk of altercation and inappropriate interaction due to the resident's poor insight and judgement related to dementia. A nurse's note dated 12/15/24 at 10:22 PM identified that Resident #1 remained on every 15-minute checks with attempts to enter other residents' rooms but was redirected. The Resident Care Plan (RCP) update on 12/16/24 identified that Resident #1 has a history of hugging, stroking and kissing other staff and residents on the hands and face and that the resident is approved by the Power of Attorney (POA) to have intimate relationships with peers with interventions that included to encourage the resident to express feelings appropriately, staff is to complete every fifteen (15) minute checks, and that family consented to initiation and acceptance of affection and intimate relationships. A nurse's note dated 12/17/24 at 10:12 PM identified that Resident #1 was attempting to enter other residents' rooms and was redirected multiple times. A nurse's note dated 12/19/24 at 10:52 PM identified that Resident #1 attempted to enter other residents' rooms and was redirected. Review of the December 2024 and January 2025 Medication Administration Record (MAR) for Resident #1 identified that Resident #1 was being monitored for impulsivity, restlessness, entering peers' rooms, removing items from carts, verbal outbursts and unprovoked crying but did not differentiate each behavior. The charting identified that these behaviors were observed intermittently on all shifts. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Registered Nurse (RN) #4 (Regional Nurse) on 1/7/25 at 12:10 PM identified that the facility was unable to locate healthcare proxy paperwork for Resident #1 and placed a follow-up call to Person #1 (Resident #1's listed health care proxy on the face sheet) and it was reported by Person #1 that there was no legal paperwork and that Person #1 was the next of kin, not the healthcare proxy, therefore, it should not have been documented in Resident #1's clinical record that Person #1 could make decisions regarding Resident #1's intimate relationships within the facility. Interview with the Director of Nursing Services (DNS) and Assistant Director of Nursing Services (ADNS) on 1/7/24 at 9:02 AM identified that Resident #2 had a doorway stop sign as a deterrent to keep wandering residents out of specific rooms that were identified as frequently visited by wandering residents. The stop signs do not require a physician's order, as they are a nursing measure, and they do not input their use into the plan of care for specific residents. Interview and Observation with Nurse Aide (NA) #2 on 1/6/25 at 12:50 PM identified that Resident #1 will often enter Resident #2's room, reporting that there is supposed to be a stop sign at the doorway to prevent wandering residents, however, upon observation with the surveyor the stop sign was not in place to Resident #2 ' s doorway. Interview with Licensed Practical Nurse (LPN) #2 on 1/6/25 at 12:09 PM identified that on 12/14/24 she observed Resident #1 in Resident #2's bed both covered with a sheet. She reported that when she entered, the stop sign was not in place at the doorway. She identified that she observed Resident #2's hand under the sheet move from between Resident #1's legs to visible above the sheet and Resident #1 was naked from the waist down. LPN #2 identified that Resident #1 had a history of wandering into other residents' rooms. Interview with LPN #1 on 1/6/25 at 10:50 AM identified that Resident #1 had a history of entering Resident #2's room prior to the incident on 12/14/24, as well as other residents' rooms, Resident #1 would either push through or crawl under the stop sign on the doorways and lay down on other residents' beds when he/she gets tired. LPN #1 identified that on 12/14/24 at 9:45 PM she entered Resident #2's room and observed Resident #1 in Resident #2's bed under the sheet. LPN #1 stated that she observed Resident #2's arm movement under the sheet move from Resident #1's groin area to out from under the sheet, Resident #2 stated Am I in trouble? Resident #1 was noted with his/her gown lifted to the chest area and was naked from the waist down, Resident #2 had underwear on, but no shirt. LPN #1 further identified that since the 12/14/24 incident, she has observed Resident #1 crawl under the stop sign to Resident #2's room and she has had to remove Resident #1 from Resident #2's bathroom one time that she could recall. LPN #1 further identified that she did not report Resident #1's behaviors both prior to and after the incident on 12/14/24 because all staff were aware. Interview with Registered Nurse (RN) #1 (3:00 PM to 11:00 PM nursing supervisor) on 1/6/25 at 2:19 PM identified that on 12/14/24 Resident #1 and Resident #2 were observed in Resident #2's bed and when the sheet was removed Resident #1 was without a brief or clothing from the waist down. When Resident #2 was questioned he/she stated that Resident #1 had gotten into his/her bed while he/she was sleeping. RN #1 stated that prior to the 12/14/24 incident, she had seen Resident #1 crawl under the stop sign at the doorway of Resident #2's room and other residents who have a stop sign at the doorway, reporting that the stop sign is an ineffective intervention at keeping Resident #1 out of other residents' rooms, however, did not report this to the DNS. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with NA #1 on 1/6/25 at 11:25 AM identified that Resident #1 had always wandered into Resident #2's room prior to the incident on 12/14/24. NA #1 identified that subsequent to the incident between Resident #1 and Resident #2 on 12/14/24, Resident #1 continues to crawl under the stop sign at Resident #2's door and he has found Resident #1 in Resident #2's room numerous times and had to redirect him/her out of the room. NA#1 identified that he didn't report these behaviors to anyone prior to or subsequent to the incident because all licensed nurses and NAs had also observed Resident #1 going under the stop sign and have found the resident in Resident #2's room. Interview with Social Worker #1 on 1/6/25 at 11:36 AM identified that Resident #1 had a history of wandering throughout the unit and when he/she would get tired, he/she would lay down in other residents' beds. Social Worker #1 identified that due to Resident #1's cognition, it was unknown if he/she consented to any intimacy with other residents within the facility. She reported that the staff continued to redirect the resident out of rooms as needed and continued to utilize the stop sign in Resident #2's doorway to deter the resident from entering Resident #2's room but identified that it wasn't effective in keeping Resident #1 out of Resident #2's room but would slow him/her down. Interview with the DNS on 1/6/25 at 1:04 PM identified that the 12/14/24 incident involving both Resident #1 and Resident #2 were found to be unsubstantiated following the investigation, as Resident #1 had a history of becoming aggressive and agitated when he/she didn't want to do something and stated he/she was calm on assessment, had no injuries and could not prove that intimate relations took place as the sheet was covering the residents on initial observation. The DNS identified that she was unaware prior to the incident that Resident #1 was going under the stop sign and entering Resident #2's room frequently. Subsequent to 12/14/24, the resident was placed on every fifteen (15) minute observations which she believed to be effective, as staff had not reported to her that Resident #1 had been continuing to go into Resident #2's room and that the stop sign in Resident #2's doorway was ineffective. She identified that if she had been aware she was unsure of what interventions she would have put into place, stating that she would have to do an investigation to determine the best interventions to implement. Additionally, she identified that although not reflected in the Plan of Care (POC) the doorway stop sign should have been in place to Resident #2's doorway to prevent wandering residents from entering Resident #2's room but she was unsure why it was not in place on observation on 1/6/24 or on 12/14/24 when the incident occurred, however stated they do their best to reapply the stop sign as soon as it's identified that it's not in place. Review of the Abuse policy dated 01/2023 directed, in part, that each resident has the right to be free from abuse. Sexual abuse means non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to sexual harassment, sexual coercion, or sexual assault. Staff training should include appropriate interventions to deal with aggressive and/or catastrophic reactions of residents, what constitutes abuse, that abuse allegations require immediate action and how to identify residents who have the potential for becoming victims of abuse. The facility will continue to provide individualized care plans that identify risk factors of residents as well as plans for protecting their rights. After the incident occurs the interdisciplinary team will update the person-centered care plan with appropriate interventions.