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	06/24/2025

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 - 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. (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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #6) reviewed for a resident-to-resident altercation, the facility failed to ensure Resident #6 was free from physical abuse. The findings include:Resident #6's diagnoses included post-traumatic stress disorder, anxiety disorder, major depressive disorder, dementia, psychotic disorder with delusions, and moderate intellectual disabilities. The RCP dated 7/4/24 identified Resident #6 is selective with leisure time pursuits and needs moderate encouragement. Interventions identified: provide in room activities to promote mental stimulation and added socialization, resident may have childlike personality, may be attention seeking, and likes to hold stuffed animals/toys. The quarterly MDS assessment dated [DATE] identified Resident #6 had severe cognitive impairment and required supervision or touching assistance for bed mobility and transfers, required substantial/maximal assistance with toileting and hygiene, partial to moderate assistance with dressing, transfers and ambulation. The nurse's note dated 10/15/24 at 2:32 PM identified Resident #6 had been hit on the cheek by Resident #74. Resident #6 let out a yell but was easily calmed. The residents were separated and notifications made to the psychiatric provider, APRN, police, family and social worker. The note further identified Resident #6 was assessed and noted no redness, bruising or open areas to the face. A Reportable Event report dated 10/15/24 identified Resident #6 was in the doorway to his/her room when Resident #74 was walking by and slapped him/her on the cheek. The incident was witnessed by the Recreation Director Resident #74's diagnoses included adjustment disorder with anxiety, unspecified dementia without behavioral disturbance, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #74 had severe cognitive impairment, was independent with bed mobility, toileting, dressing, hygiene, transfer, and ambulation. The Resident Care Plan (RCP) dated 10/4/24 identified Resident #74 had the potential to be physically aggressive scratching pinching related to being angry. Interventions directed to evaluate and address for contributing sensory deficits, when the resident becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff is to walk calmly away and approach later. The nurse's note dated 10/15/24 at 2:07 PM identified that around 10:55 AM the Recreation Director notified the nurse that Resident #74 was walking past Resident #6 who was standing in the doorway to his/her room when Resident #74 slapped him/her on the cheek. The residents were separated, and Resident #74 was placed on 1:1 observation. The psychiatric provider, APRN, police, family, and social work were notified. Resident assessed. An investigation statement dated 10/15/24 at 10:55 AM by Recreation Aide #1 identified Resident #74 was agitated, aggressive, impulsive, and continued to grab residents/items and not let go. Interview on 6/24/25 at 7:30 AM with the Recreation Director identified she witnessed Resident #74 trying to go into Resident #6's room. Resident #6 is very protective of her room and all of her stuff and does not like people in his/her room. Resident #6 was standing in the doorway when Resident #74 tried to enter the room and Resident #74 slapped Resident #6 on the cheek. Resident #6 was crying following the incident and was upset at what had transpired, she needed to be calmed down. Both residents were separated, and the supervisor was contacted. No marks were noticed at the time of the incident. Although she saw what transpired she did not intervene at the time of the incident as she was down the hall. Interview on 6/24/25 at 9:30 AM with Regional Nurse #1 identified that every resident in the facility has the right to be free from abuse. The facility failed to protect Resident #6 from physical abuse by Resident #74. A review of facility Abuse Policy each resident has the right to be free from abuse, neglect and misappropriation of resident property and exploitation. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish.