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	07/21/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the 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 0580 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, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for falls, the facility failed to ensure an assessment was performed and a provider was notified of a change in condition after multiple reports of a change in condition was made by facility staff over an 11 day period of time. The findings include:Resident #1's diagnoses included dementia, abnormalities of gait, and muscle weakness. Physician's orders dated 5/21/25 directed Physical Therapy five (5) times per week for six (6) weeks and Occupational Therapy five (5) times per week for six (6) weeks.The admission Minimum Data Set assessment dated [DATE] identified Resident #1 was severely cognitively impaired, required maximum assistance for hygiene, showers, and bed mobility, was dependent on staff for dressing, toileting, transfers, and ambulation, and used a wheelchair for mobility. The Resident Care Plan (RCP) dated 5/24/25 identified Resident #1 had a self-care deficit and was at risk for falls. Interventions directed assistance with all care including transfers, wheelchair use for mobility, appropriate footwear, and for the resident to be in common areas while awake. The Physical Therapy (PT) note by Physical Therapist (PT) #1 dated 5/30/25 identified Resident #1 ambulated two (2) times forty (40) feet within his/her room and into the hallway using the two (2) wheeled walker with minimal assistance and verbal cues.The nurse's note dated 5/30/25 at 5:40 PM by RN #1 (3 PM to 11 PM supervisor) identified Resident #1 was observed sitting on the floor in his/her room at the bedside with his/her back resting on the bed frame. Resident #1 was unable to explain how he/she ended up on the floor, moved all extremities without issue, lower extremities were without deviation, rotation or shortness. Resident #1 was assisted to a standing position and took a few steps without issue. The Advanced Practice Registered Nurse (APRN) was updated and ordered monitoring per facility protocol for an unwitnessed fall. The PT note by PT #1 dated 6/2/25 identified Resident #1 was approached multiple times throughout the day but was too lethargic to safely perform PT activities.The PT note by PT #1 dated 6/5/25 identified once Resident #1 was standing, he/she was unable to tolerate single leg weight bearing to the left lower extremity. Upon palpation of the left hip, Resident #1 reported pain/wincing at the lateral aspect of the hip and reported pain when passively ranged into hip flexion while seated. Therapy was stopped and nursing staff were updated on left hip pain. The nurse's note dated 6/5/25 at 11:31 AM by LPN #3 (7 AM to 3 PM charge nurse) identified Resident #1 was out of bed in the wheelchair and a family member was visiting. The family member requested pain medication for left knee and left leg pain. Tylenol was administered with good relief.The PT note by PT #1 dated 6/9/25 identified Resident #1 had significant difficulty pivoting due to difficulty weight bearing through the left lower extremity and was unable to march in place due to inability to weight shift.The PT note by PT #1 dated 6/10/25 identified Resident #1 was having significant difficulty bearing full wight through the left lower extremity and unable to take a step forward with the left lower leg. When Resident #1 stepped forward with the right lower leg, the left lower leg buckled due to inability to weight bear and was unable to pivot feet during transfer. Recommeded transfer status be downgraded to use pivot transfer equipment to help ease pain. Nursing staff updated on decline and downgrade of transfer status from bed to chair.The PT note by the Rehabilitation Director (PTA #1) dated 6/12/25 identified Resident #1's sudden change had impacted functional status and safety.The nurse's note by LPN #2 (7 AM to 3 PM charge nurse) dated 6/16/25 at 9:40 AM identified she was called to Resident #1's room by the NA to observe Resident #1's left leg.The physician progress note dated 6/16/25 identified the APRN ordered an x-ray of the left hip which revealed an acute left hip fracture, with concern of an additional fall after the 5/30/25 fall due to a new skin tear to the left outer wrist. The x-ray identified an acute left hip fracture at the neck of the left femur with the left leg externally rotated. Resident #1 was sent to the Emergency Department for further evaluation and treatment. The x-ray of the left hip dated 6/16/25, identified an angulated and displaced intertrochanteric fracture of the left hip and severe osteopenia.Review of the nurse's notes from 6/5/25 to 6/16/25 failed to identify the APRN was notified of the change in condition reported by physical therapy to the nursing staff. The notes failed to identify an assessment after physical therapy reported their findings to the nursing staff. A statement dated 6/16/25 by PT #1 identified he/she reported concerns to nursing staff and requested the concerns be discussed during the facility Medicare meeting on 6/10/25. A statement dated 6/16/25 by OTA #1 identified he/she reported Resident #1's knee pain to the charge nurse. A statement dated 6/16/25 by PTA #1 identified he/she addressed mobility concerns throughout the prior week during morning meetings and discussed the change in Resident #1's

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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)

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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, facility documentation, facility policy and interviews for two of three sampled residents (Residents #2 and Resident #3) who were reviewed for an allegation of resident-to-resident sexual abuse, the facility failed to provide adequate monitoring for a resident who had a history of wandering and was observed by facility staff wandering into other resident rooms. The findings include:1. Resident #2's diagnoses included dementia, anxiety, and difficulty ambulating. The Resident Care Plan (RCP) dated 5/13/25 identified Resident #2 had a self-care deficit and wandered throughout the unit and in and out of other residents' rooms. Interventions directed to offer structured activities, comfort support and redirection when wandering into other residents' rooms. The annual Minimum Data Set assessment dated [DATE] identified Resident #2 had severe memory recall deficits (Brief Interview for Mental Status (BIMS) score of 2), required maximum assistance from staff for eating, hygiene, showers, toileting, and dressing and was independent with mobility. 2. Resident #3's diagnoses included dementia and an unsteady gait. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had severe memory recall deficits (Brief Interview for Mental Status (BIMS) score of 5), required touching assistance for all care and was independent with mobility. The Resident Care Plan dated 6/13/25 identified Resident #3 had a self-care deficit, and interventions directed to provide set-up assistance for care as needed. The nurse's note dated 7/4/25 at 10:17 PM by RN #1 (3 PM to 11 PM supervisor) identified Resident #2 went in and out of other residents' rooms before dinner with frequent redirection. Resident #2 did not exhibit signs of discomfort, was alert and confused per baseline, and was placed on one (1) to one (1) supervision after dinner. Review of the clinical record failed to identify implementation of increased monitoring and care-planned interventions, including structured activities and comfort support, to address Resident #2's wandering behaviors observed prior to dinner. The nurse's note dated 7/4/25 at 10:56 PM by RN #1 identified Resident #2 was found in Resident #3's room. NA #1 witnessed Resident #2 lying in a supine position in the bed belonging to Resident #3's roommate. Resident #2's pants were down, and the incontinence brief was open on one side. Resident #3 was observed partially undressed attempting to initiate sexual contact. The incident was immediately stopped, and Resident #2 was removed from the room. No physical injuries were noted, the Director of Nursing (DON), family members, police, and physician were notified, and psychology and social work referrals were made. Both residents were placed on one (1) to one (1) observation for safety. A written statement by NA #1 dated 7/4/25 identified she observed Resident #2 lying in the bed of Resident #3's roommate. NA #1 noted that Resident #2 frequently wandered into other residents' rooms and had a particular interest in that specific bed, for unknown reasons. At the time of observation, Resident #2's pants were lowered to the right calf, and the incontinence brief was open on the right side. Resident #3 was observed with a hand on his/her own genitalia and was attempting to engage in sexual contact with Resident #2. The behavior ceased immediately upon NA #1 entering the room. The Facility Accident and Incident Report dated 7/4/25 identified there was an incident between Resident #2 and Resident #3 that occurred at 6:45 PM. One (1) to one (1) monitoring was initiated because of the incident. The Director of Social Services (DSS) note dated 7/7/25 at 11:10 AM identified Resident #3 reported, we almost did it when asked about the incident on 7/4/25. When the DSS inquired what it meant Resident #3 responded, having sex, but it didn't happen because the nurse stopped us. Resident #3 further identified both residents talked about it and agreed. Resident #3 denied physical touch and identified him/her and Resident #2 were undressing themselves and Resident #2 was lying in the bed while Resident #3 was standing next to the bed when the nurse came in. The Psychiatric Evaluation note dated 7/8/25 identified Resident #3 was seen as follow up by the Advanced Practice Registered Nurse (APRN). Resident #3 was seen partially undressed with apparent intent to engage in inappropriate behavior with another cognitively impaired, partially undressed resident who had wandered into his/her room. Resident #3 appeared guarded on the discussion around the incident with Resident #2 on 7/4/25. He/she perseverated on the incident and identified feeling staff and the resident's roommate set him/her up and that Resident #2 told him/her to do it. The APRN further identified that while no physical contact occurred due to staff intervention, the behavior raised concern regarding judgement, insight and impulse control. Interview with RN #1 on 7/21/25 at 10:35 AM identified he was in the dining room with the residents during dinner on 7/4/25 and saw Resident #2 ten (10) minutes before NA # 1 requested he go to Resident #3's room. Upon entering Resident 3's room, Resident #3 was on his/her side of the room fully