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	06/24/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policies and interviews, for two (2) of four (4) sampled residents (Residents #1 and #4) who required staff assistance for personal care, the facility failed to ensure Residents #1 and #4 were protected from verbal abuse by a staff member when the staff member repeatedly made inappropriate, offensive comments. The findings include:1.Resident #1's diagnoses included Parkinsons Disease, mood disorder, psychotic disorder with hallucinations, anxiety, and depression.The annual Minimum Data Set assessment dated [DATE] identified Resident #1 as cognitively intact (Brief Interview for Mental Status (BIMS) score of (15) and required moderate assistance from staff for personal care including incontinence care.The Resident Care Plan dated 5/13/26 identified Resident #1 was incontinent of bowel and bladder. Interventions directed personal care with each incontinent episode, ensure an unobstructed path to the bathroom, check every two (2) hours for incontinence and change clothing as needed.The nurse's note dated 5/24/26 at 4:51 PM by RN #1 identified Resident #1 made allegations of multiple accounts of verbal abuse. Resident #1 would not disclose specific details. Resident #1 denied physical abuse. Allegations were reported to the physician, police, administration and family and an investigation was initiated per facility protocol. Resident #1 was in no apparent distress and had no signs of injury.The nurse's note dated 5/24/26 at 7:18 PM by RN #1 identified Resident #1 reported allegations that a staff member (later identified as NA #1) made inappropriate comments during care. Resident #1 was unable to state an exact date of when the incidents occurred. The Social Work note dated 5/25/26 at 10:33 AM by the Director of Social Services (DSS) identified Resident #1 expressed concerns related to NA #1 making inappropriate comments. Resident #1 reported NA #1 made several inappropriate comments about Resident #1's body when assisting with care at night. Resident #1 identified he/she asked NA #1 to stop, informed NA #1 the comments were inappropriate and, in response, NA #1 stated the comments were not inappropriate in his culture. Resident #1 informed the DSS that he/she began avoiding assistance from NA #1, unless it was necessary and began using a different type of underwear to avoid interaction with NA #1. Resident #1 did not report the allegations because he/she did not want to get anyone in trouble and because he/she was uncomfortable.The physician's note dated 5/26/26 at 2:30 PM by the Advanced Practice Registered Nurse (APRN) #1 identified Resident #1 reported NA #1 made inappropriate sexual comments about Resident #1's body during care. Resident #1 asked for a medium-sized brief and NA #1 responded asking if Resident #1 needed a larger size because he/she had a big a** and on a separate occasion asked if Resident #1 needed an extra-large. Resident #1 felt uncomfortable and upset and avoided asking NA #1 for assistance. Resident #1 verbalized relief NA #1 was no longer providing care. Resident #1 denied trauma but stated comments were uncomfortable and he/she did not appreciate remarks about his/her body. Initially hesitant to report due to not wanting to get anyone in trouble. Resident #1 was psychiatrically stable, calm, cooperative, and in no acute distress during evaluation.Interview with the DSS on 6/23/26 at 2:35 PM identified she spoke with Resident #1 and Resident #1 identified NA #1 said something to the effect of Resident #1 had a big butt on more than one occasion when assisting Resident #1 with hygiene. Resident #1 identified (continued on next page)

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	he/she told NA #1 it was not appropriate and NA #1 proceeded to tell Resident #1 that it was an appropriate comment in his culture. Resident #1 further identified avoiding receiving care from NA #1 unless absolutely needed after the comments were made.Interview with Resident #1 on 6/24/26 at 10:40 AM identified when he/she asked NA #1 to get him/her a brief, NA #1 brought an extra-large and Resident #1 told NA #1 that he/she wore a size medium. NA #1 responded to Resident #1 that, you have a big a** on at least three (3) occasions. Resident #1 told NA #1 the comment was inappropriate to which NA #1 responded it would be considered a compliment in his country. Due to comments made, Resident #1 stopped wearing tabbed briefs at night which he/she required assistance with and began wearing pull-up briefs which he/she wore during the day and could manipulate independently, so that Resident #1 would not need to ask NA #1 for assistance.Interview with NA #1 on 6/24/26 at 1:15 PM identified he provided incontinence care for Resident #1 and initially assisted with tabbed briefs but the facility stopped providing the tabbed briefs and Resident #1 began wearing pull-up briefs which he/she no longer needed assistance with. NA #1 further identified an incident when he brought Resident #1 a large size brief and Resident #1 stated he/she wore a medium. NA #1 responded he thought his/her stomach was a size large to which Resident #1 stated, are you telling me I have a big butt?' At that point NA #1 told Resident #1 people where he is from see that as a compliment. NA #1 denied any further allegations.2.Resident #4's diagnoses included atrial fibrillation, anxiety, and depression.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 as cognitively intact (Brief Interview for Mental Status (BIMS) score of 13) and required moderate assistance from staff for personal care including incontinence care.The Resident Care Plan dated 5/15/26 identified Resident #4 had a self-care deficit and was incontinent of bladder. Interventions directed assistance with personal care as needed and with each incontinent episode, ensure an unobstructed path to bathroom, check Resident #4 every two (2) hours for incontinence, and change clothing as needed.The nurse's note dated 5/24/26 at 7:19 PM by RN #1 identified Resident #4 reported an allegation that NA #1 made inappropriate comments during care. Emotional support was provided to Resident #4. There were no physical findings. The Director of Nursing (DON), Administrator, police, physician, and a family member were notifiedThe Social Work note dated 5/25/26 at 10:19 AM by the DSS identified Resident #4 expressed concerns related to NA #1 making inappropriate comments. Resident #4 informed the DSS that he/she told NA #1 that he/she did not like the language used. Resident #4 identified NA #1 continued making comments and Resident #4 did not feel comfortable repeating the comments. Resident #4 did not report the allegations to anyone because he/she felt shame and did not want to cause trouble.The physician's note dated 5/26/26 at 2:15 PM by APRN #1 identified Resident #4 was alert and oriented, with intermittent forgetfulness. No acute distress was observed. When asked about the allegation, Resident #4 reported that NA #1 made statements suggesting that when another male patient is done with Resident #4, he (NA #1) will take him/her (Resident #4) and made unsolicited comments about his/her breasts. Resident #4 stated he/she did not report this at the time, explaining that he/she feared others might think he/she was trying to get attention. Resident #4 further expressed that he/she perceived NA #1 as predatory and felt he should not be providing care to people with medical infirmities.Interview with the DSS on 6/23/26 at 2:35 PM identified she spoke with Resident #4 and Resident #4 identified that NA #1 used language he/she did not feel comfortable repeating on more than one occasion. Resident #4 had not reported anything in the past because he/she felt shame regarding the comments.Interview with Resident #4 on 6/24/26 at 10:00 AM identified NA #1 made him/her feel uncomfortable on several occasions. Resident #4 described one incident when he/she was in the bathroom and did not realize the door was not closed all the way. When Resident #4 looked up, he/she saw NA #1 staring through the door while Resident #4 was seated on the toilet. Resident #4 did not say anything because he/she was embarrassed that he/she did not close the door all the way.Resident #4 identified having a close male friend in the facility and on one occasion alleged NA #1 said, when the male resident is done f'ing you, I will take over. Resident #4 further identified NA #1 made other comments and said, you (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have nice tits. Resident #4 did not initially report the concerns but after overhearing others discussing concerns about the same NA felt empowered to come forward with the concerns. Resident #4 further identified she told LPN #1that she did not want NA #1 providing care for him/her but would not give LPN #1 a reason. Resident #4 told LPN #1 he/she did not like NA #1 and would prefer LPN #1 provide care as he/she felt more comfortable receiving care from LPN #1 who was kind. Resident #4 further identified he/she had a duck on his/her walker that squeaked when squeezed and whenever NA #1 would walk by Resident #4 he would squeeze the duck and say, I am going to get you making Resident #4 more uncomfortable. Resident #4 became teary eyed during the interview and voiced relief after sharing specifics of allegations. Throughout the interview, Resident #4 would not say the offensive/inappropriate words but rather spelled them. Resident #4 had not previously felt comfortable repeating the specific words NA #1 used because Resident #4 was embarrassed and ashamed by the encounters with NA #1.Interview with APRN #1 on 6/24/26 at 12:35 PM identified Resident #4 was unable to clarify if the comments NA #1 made to him/her were of a sexual nature. Resident #4 had some recent memory challenges following an episode of COVID but had no history of fabricating events. After informing APRN #1 of the interview conducted with Resident #4 and the further clarification of Resident #4's initial statements along with Resident #4's emotional reaction during the interview, APRN #1 identified she believed Resident #4 was negatively impacted from the actions of NA #1.Interview with NA #1 on 6/24/26 at 1:15 PM identified he did not provide personal care for Resident #4, and he denied all allegations made regarding care and comments to Resident #4.Interview with the DON on 6/24/26 at 2:15 PM identified on 5/24/26 the President of Resident Council brought three (3) written statements by Residents #1, #2, and #4 to RN #1 regarding allegations of abuse against NA #1. The facility immediately initiated an investigation and suspended NA #1 pending the outcome of the investigation. The facility determined NA #1 failed to follow facility expectations regarding customer care and made comments to residents that made them feel uncomfortable. NA #1 made the comments repeatedly despite being asked not to by the residents. NA #1 was terminated. The DON further identified the facility failed to follow the abuse policy because based on the facility abuse policy, the statements made by NA #1 to the residents was verbal abuse.Review of the facility Abuse Policy identified that each resident had the right to be free from abuse and that verbal abuse was defined, in part, as the use of oral language that willfully includes disparaging and derogatory terms to residents.Although attempted, an interview with LPN #1 was not obtained. Review of facility documentation identified that a Plan of Correction was initiated immediately: Staff training regarding Resident Rights and the Abuse Policy including investigating and reporting was initiated on 5/24/26. Residents were also educated on reporting allegations of mistreatment.Audits were scheduled to be completed weekly times four (4) weeks then monthly times three (3) months which included questions to determine if residents were treated inappropriately or had care concerns.Audits were to be reviewed at the monthly QAPI meetings.The Administrator and Director of Nursing were responsible for the Plan of Correction.Alleged compliance date of 6/22/26 The Plan of Correction was reviewed during an on-site visit on 6/24/26 and the facility met all components for past non-compliance.