STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075333	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Rehabilitation and Healthcare Center	385 W Center St Manchester, CT 06040

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure neurological monitoring was completed timely after an unwitnessed fall and the facility failed to ensure the facility policy directed staff when to conduct neurological monitoring after an unwitnessed fall. The findings include: Resident #1's diagnoses included Parkinson's, cervicalgia (neck pain), and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of thirteen out of fifteen, indicative of no cognitive impairment and ambulated independently with a rolling walker. The Resident Care Plan (RCP) dated 8/20/2025 identified ADL self-care deficit. Interventions directed independent with bed mobility, transfers, toilet use with use of grab bars, and independent ambulation up to 250 feet as tolerated. Review of physical therapy Discharge summary dated [DATE] identified Resident #1 was able to ambulate 300 feet safely on level surfaces with supervision using rolling walker. Review of facility reportable event dated 11/10/1025 at 10:30 AM identified on 11/9/2025 at approximately 3:40 AM Resident #1 was observed on the ground outside of his/her bedroom window and stated he/she wanted to leave to gain his/her independence. Assessment identified Resident #1 was able to move all extremities without difficulty, denied hitting his/her head and pain, and was noted to have skin tears to his/her bilateral hands. Neurological assessment was within normal limits. The report further identified Resident #1 had a recent psychiatric evaluation that identified he/she has full decisional capacity, was self-responsible and the facility was planning his/her discharge to the community. Resident #1 was transferred to the hospital and returned the same day with no new orders. On 11/9/2025 at approximately 4:20 PM, Resident #1 complained of right side and midback pain and was transferred to the hospital for evaluation, and hospital imaging revealed fractures of right ribs 10 and 11. Nursing note dated 11/9/2025 at 4:56 AM (written by RN #1) identified pupil reactions were equal and reactive to light, had equal strong hand grasps, and Resident #1 was transferred to the hospital at approximately 4:40 AM. Review of the facility Head Injury Observation dated 11/9/2025 identified neurological monitoring was completed at 3:45 AM, 4 AM, 4:30 AM and beginning at 5 AM indicated Resident #1 was hospitalized . Nurses note dated 11/9/2025 by RN supervisor indicated resident returned from emergency room at 8:45 AM, RN and was placed on every 15-minute checks. Record review and review of the facility Head Injury Observation dated 11/9/2025 identified neurological monitoring indicated resident was hospitalized and failed to identify neurological monitoring/assessments were completed or documented upon Resident #1's return to the facility at approximately 8:45 AM. Review identified hourly neurological monitoring was due every hour at 9 AM, 10 AM, 11 AM, and then every four (4) hour assessments were due to begin at 3 PM. The Head Injury Observation form indicated the resident was hospitalized at 9 AM (when he/she had returned at 8:45 AM), at 10 AM and at 11 AM. Further, LPN #2 documented that a neurological assessment was completed at 1 PM, five (5) hours after Resident #1 was due to be re-assessed. Nursing note dated 11/9/2025 at 4:45 PM indicated Resident #1 was heard yelling and cursing in the hallway near the recreation room, and stated, I can't breathe, I think I broke my ribs, I think I punctured something. Resident #1 was transferred to the hospital. Additional record review failed to identify Resident #1 refused any neurological assessments after his/her return from the hospital at 8:45 AM. Review of hospital paperwork dated 11/9/2025 at 8:55 PM identified C-2 (cervical vertebra number 2) fracture verses chronic non-union of prior C-2 fracture noted on 1/2025, and right number 10 and 11 rib fractures. Facility reportable event summary dated 11/14/2025 identified Resident #1 did not return from the hospital. Prior to the incident Resident #1 learned that a long-awaited discharge to an assisted living facility had fallen through and had agreed to remain at the facility and work with social services for an alternate placement. Resident #1 expressed the desire to be discharged from the hospital to community and was discharge to a different facility. Interview, clinical record and facility documentation review with LPN #2 on 11/19/2025 at 8:32 AM identified she assessed Resident #1's vital signs (blood pressure, pulse and respirations) at 9 AM upon return from the hospital and Resident #1 refused neurological monitoring at that time, however. LPN #2 stated she did not document Resident #1's refusal and she should have. LPN #2 initially indicated resident's neurological monitoring was due every four (4) hours after his/her return from the hospital, and stated she next completed neurological checks at 1 PM. Further, LPN #2 stated she did not recall completing, or attempting to complete the neurological assessments at 10