STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Manchester Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation/policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for allegations of neglect, the facility failed to notify a provider following a dental exam performed at the facility, which identified devastated dentition requiring further intervention, after the follow up visits were scheduled but not conducted or rescheduled at the facility, for six (6) consecutive visits over a period of 6 months. The findings include:Resident #1?s diagnoses included dementia without behavioral disturbances, Parkinson's disease (a progressive movement disorder of the nervous system), stage 3 chronic kidney disease (mild to moderate loss of kidney function), hypothyroidism, protein-calorie malnutrition and type 2 diabetes mellitus.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition with a staff assessment for mental status conducted which indicated short-term and long-term memory problems with no recall ability and was dependent on staff for personal hygiene, bed mobility and transfers. The MDS identified Resident #1 had three (3) unhealed stage four (4) pressure wounds (pressure ulcers involving full thickness tissue loss with exposed muscles, tendons or bone) that were present on admission. The Resident Care Plan (RCP) dated 8/19/25 identified Resident #1 had oral/dental health problems related to functional impairment limiting the ability to perform oral hygiene and poor oral hygiene. Interventions included providing oral hygiene, inspecting the oral cavity for abscesses, sores, and/or signs and symptoms of infection, and monitoring/documenting/reporting to the provider signs and symptoms of oral/dental problems needing attention.Dental documentation dated 9/25/25 identified a dental cleaning every three (3) months was recommended due to poor oral health and Resident #1 had cavities on every tooth and should have all remaining teeth removed. The documentation identified the teeth were likely infected or a great source of bacteria, Resident #1 would be healthier without the devastated dentition and an FMX (a full mouth series that captures every tooth, root and surrounding bone structure in the mouth) was recommended as dentition was destroyed and x-rays would help in determining the best place to refer the resident.The Dental Group Schedule dated 10/10/25 for the dental hygienist identified Resident #1 was not treated because he/she was ?not on her list when she synced'.The Dental Group Schedule dated 11/13/25 for the dental hygienist identified Resident #1 was not treated because he/she was at the hospital.The Dental Group Schedule dated 1/21/26 for the dental hygienist identified Resident #1 was not treated because he/she was at the hospital.The Dental Group Schedule dated 2/12/26 for the dental hygienist identified Resident #1 was not treated because he/she was at the hospital.Review of the clinical record from 9/25/25 through 3/25/26 failed to identify progress notes regarding Resident #1's dental visit, need for x-rays or dentition, or that the provider was notified of the issues identified during the 9/25/25 visit.Interview with the Director of Social Services on 3/25/26 at 1:45 PM identified she was responsible for managing outside providers who provide services at the facility, including dental services. She reported she ensured residents were added to the list when needed and identified Resident #1 was on the list to be seen but was either at the hospital or the provider did not have time to see Resident #1. She identified Resident #1 (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	was on the list for December 2025 but was not seen by the provider and dental did not go to the facility in March 2026. She reported she saw the 9/25/25 dental note for Resident #1 but did not ensure nursing was aware of the issues. She identified she should have notified nursing for additional follow-up. Interview with the DON on 3/25/26 at 2:14 PM identified she was not made aware of the 9/25/25 dental visit for Resident #1 or the missed hygienist visit on 10/10/25 and although the Dental Group Schedules for 11/13/25, 1/21/26 and 2/12/26 were addressed to her attention, she was unaware Resident #1 missed dental visits from 10/10/25 through 2/12/26. She reported that the Director of Social Services should have notified nursing and a provider of the missed dental visits. The DON identified the facility should have contacted the dental group for follow-up options or reached out to Resident #1's representative to see how he/she wanted to proceed.Interview with APRN #2 on 3/25/26 at 2:44 PM identified she was unaware of the 9/25/25 dental visit note for Resident #1 and should have been notified. She identified that if she were aware she would have evaluated the resident and provided treatment, if necessary, until the resident could be seen by dental. Additionally, she reported that once it was identified that Resident #1 missed the following appointment due to hospitalization, the facility should have followed up with the dental provider or spoken with Resident #1's representative to make alternative follow-up arrangements.Review of the Notification of Changes policy (undated) directed, in part, the facility must inform the resident, consult with the resident's provider and/or notify the resident's family member or legal representative when there's a change requiring such notification such as significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status or circumstances that require a need to alter treatment.Although requested, a facility policy for outside consults and follow-up was not available.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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) sampled residents (Resident #1) reviewed for allegations of neglect, the facility failed to ensure appropriate monitoring and implementation of interventions to prevent skin breakdown for a dependent resident who was identified as having a high risk for developing pressure sores (wound), including failure to ensure offloading boots were properly managed and failure to assess the skin under the boots every shift, resulting in the development of an avoidable pressure wound to the left dorsal foot that was not identified timely and progressed to a full thickness wound requiring ongoing treatment. The findings include:Resident #1?s diagnoses included dementia without behavioral disturbances, Parkinson's disease (a progressive movement disorder of the nervous system), stage 3 chronic kidney disease (mild to moderate loss of kidney function), hypothyroidism, protein-calorie malnutrition and type 2 diabetes mellitus.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition with a staff assessment for mental status conducted which indicated short-term and long-term memory problems with no recall ability and was dependent on staff for personal hygiene, bed mobility and transfers. The MDS identified Resident #1 had three (3) unhealed stage four (4) pressure wounds (pressure ulcers involving full thickness tissue loss with exposed muscles, tendons or bone) that were present on admission.The Resident Care Plan (RCP) dated 8/19/25 identified Resident #1 had impaired skin integrity related to failure to thrive and immobility. Interventions included identifying risks for pressure wounds, turning and repositioning every two (2) hours, using proper positioning, transferring and turning techniques to minimize skin injury due to friction and shearing forces, a low air-loss mattress and offloading heels as tolerated.A Braden Scale for Predicting Pressure Sore Risk evaluation dated 9/16/25 identified Resident #1 was at high risk for acquiring pressure wounds.A Wound Care Specialist note by MD #2 dated 9/18/25 identified Resident #1 had been evaluated for stage 4 pressure wounds to his/her right hip, left hip and sacrum and the pressure wounds were largely stable. The note identified that a left medial foot wound (inner aspect extending from the heel to the big toe) resolved on 9/4/25.A Weekly Skin Check evaluation dated 9/21/25 by RN #4 identified no new skin issues were identified.An APRN note by APRN #2 dated 9/23/25 at 9:30 AM identified she was asked to see Resident #1, in part, for a wound to Resident #1's left foot. Resident #1 had a wound to his/her left dorsal foot and she ordered for the left dorsal foot to be cleansed with normal saline, the application of silver alginate (a highly absorbent antimicrobial wound dressing) daily to the wound bed and then covered with a clean dry dressing and changed every day shift. The note identified Resident #1 was to be seen and evaluated on Thursday by the wound team.A nurse's note by the ADON dated 9/23/25 at 12:19 PM identified she assessed Resident #1 and discovered an open area to the left dorsal foot measuring approximately 3 centimeters (cm) by 0.5 cm and reported the area was caused by Resident #1's skin rubbing against the heel booties (offloading boots). The ADON identified the offloading boots were removed, replaced with new offloading boots and Resident #1's responsible party was at the bedside and updated. The note identified RN #2 was updated and new dressing orders were obtained.A Wound Care Specialist note by MD #2 dated 9/25/25 identified Resident #1 was seen for evaluation of wounds to the right hip, left hip and sacrum in addition to a new wound to the left dorsal foot. The note identified the left dorsal foot had a full thickness wound measuring 1.1 cm by 0.9 cm by 0 cm and the wound bed was noted with 100 percent (%) slough (yellowish, soft and stringy material that forms in wounds as a result of dead or dying tissue, protein buildup and bacterial contamination and is a significant barrier to healing) and had a moderate amount of serosanguinous (appears pink or light red in color and consists of a mixture of serous fluid and small amounts of blood) drainage present. Treatment recommendations included cleansing the wound with normal saline, applying Santyl (an enzyme that removes dead tissue from skin ulcers and promotes healing) to the wound bed followed by calcium (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	alginate and covered with a dry clean dressing and offloading heels per facility protocol.Review of the clinical record from 5/16/25 through 9/23/25 failed to identify an order to utilize offloading boots or for staff to check the skin under the offloading boots every shift.A physician's order dated 12/27/25 directed licensed nurses to complete diabetic foot care every day shift (3 months after the development of the left dorsal foot wound).Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from September 2025 to March 2026 failed to identify an order for offloading boots or that the skin under the offloading boots was checked every shift. A Wound Care Specialist note written by MD #2 dated 3/19/26 identified Resident #1's left dorsal foot wound was still present, classified as a stage 4 pressure wound and measured 1.3 cm by 1.9 cm by 0.1 cm. The note identified the left dorsal foot wound had one-hundred (100) % granulation tissue (new connective tissue with blood vessels and myofibroblasts that develop at the wound site in the process of healing) and a moderate amount of serous drainage (a thin, watery clear/pale yellow fluid that's normal during the inflammatory stage of wound healing). The note recommended offloading heels per facility protocol.Interview with APRN #2 on 3/25/26 at 11:39 AM identified the left dorsal foot wound that she first assessed on 9/23/25 was not identified timely and that the area would have been reddened and boggy (indicating tissue damage from excessive fluid content, inflammation or underlying pressure injury) before opening and expelling drainage. She identified Resident #1 should have had an order in place to offload both heels while in bed and that the offloading boots were a nursing measure, but, if used, should have been removed every shift to assess the skin under the offloading boots. She identified that if the skin had been assessed every shift, the wound could have been prevented or less severe.Interview with MD #2 on 3/25/26 at 12:35 PM identified when he assessed Resident #1's left dorsal foot wound on 9/25/25, he estimated the wound existed for at least a week prior and it was highly unlikely the area opened and slough developed from the last skin check on 9/21/25 to 9/25/25 when he assessed the wound. He identified he had seen Resident #1 since his/her admission to the facility and he knew Resident #1 to utilize offloading boots. He identified that if staff had been removing the offloading boots every shift and checking the skin, the area could have been identified sooner which could have prevented progression to a full thickness wound requiring Santyl.Interview with the ADON on 3/25/26 at 12:45 PM identified that when she assessed Resident #1 on 9/23/25, she realized the left dorsal foot wound was due to the strap from the offloading boot rubbing on the dorsal aspect of Resident #1's foot but reported there was no slough at that time. She identified there should have been an order in place directing staff to utilize the offloading boots and to remove the offloading boots every shift to perform a skin check. She identified if an order had been in place and completed, the affected area could have been identified prior to an open wound developing.Although attempted, an interview with RN #4 was not obtained.Review of the Pressure Injury Prevention and Management policy (undated) directed, in part, the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcer/injuries. Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors, define and implement interventions that are consistent with resident needs, resident goals and profession standards of practice, monitor and evaluate the impact of the interventions and revise the approaches as necessary. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment, intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of intervention and modifying the interventions as appropriate. Examples of risk factors include: impaired/decreased mobility and decreased functional ability, co-morbid conditions such as end-stage renal disease, thyroid disease or diabetes mellitus, cognitive impairment, under nutrition, malnutrition, and hydration deficits and the presence of previously healed pressure injuries. Interventions will be based on specific factors identified in the risk assessment, skin assessment and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	any pressure injury assessment. Basic or routine care interventions could include: providing non-irritative surfaces. Although requested, a facility policy for offloading boots was not available.