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	05/22/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 1 residents (Resident #48) reviewed for advanced directives, the facility failed to ensure advanced directive choices were reviewed with the resident/resident representative to ensure their choices were honored. The findings include: Resident #48 was admitted to the facility on [DATE] with diagnoses that included dementia, femur fracture, and pneumonia. The hospital discharge paperwork dated 4/11/24 directed Resident #48 was a do not resuscitate (DNR). A physician's order dated 4/11/24 directed Resident #48 to be a do not resuscitate (DNR), do not intubate (DNI), and a registered nurse may pronounce (RNP). The Advanced Directive form in the clinical record dated 4/11/24 identified Resident #48 (with severe cognitive impairment) had signed him/herself as a full code. Additionally, the form had not been signed by a witness/nurse or the physician. The admission MDS assessment dated [DATE] identified Resident #48 had severely impaired cognition. The care plan dated 4/29/24 identified impaired cognition due to dementia. Interventions included discussing and educating the advanced directives with resident and/or resident responsible party and notifying physician of residents wishes regarding advanced directives. Follow the physicians order for advanced directive. Review of the clinical record dated 4/11/24-5/6/24 did not identify that Resident #48's resident representative was contacted, educated, and offered to make wishes known regarding the advanced directives for Resident #48. Interview with the Resident Representative on 5/6/24 at 8:46 AM indicated that no one at the facility has spoken to him/her regarding Resident #48's wishes for the code status since admission to the facility on [DATE] (26 days later). The Resident Representative indicated that he/she would speak with Resident #48 but was sure Resident #48 wishes were to be a DNR. S/he also indicated s/he visits daily. (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
	075333	A. Building B. Wing	05/22/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 5/6/24 at 8:51 AM indicated that the hospital code status is used for the first 24 hours, and she would expect the charge nurse or supervisor to get the wishes for the code status from the resident or resident representative within the first 24 hours. The DNS indicated that on admission if the resident was not cognitively intact like Resident #48 that two nurses, one nurse and a social worker, or the APRN/MD would call the resident representative, and both would sign the advance directive form. The DNS indicated if unable to reach the resident representative she would expect a note in the progress section stating that they tried to reach the resident representative to discuss legal matters. The DNS indicated if unable to reach resident representative within 24 hours the resident would then become a full code until the resident representative was reached to decide. The DNS indicated that after 24 hours if nursing cannot reach the resident representative, then social services would be asked to help. S/he indicated that Resident #48 had a BIMS of 2 meaning severe cognitive impairment and the resident representative would have to be called. The DNS indicated that the nurse should call the resident representative for resident ID #48 on the day of admission. After review of the clinical record, the DNS indicated she did not see a progress note that someone called the resident representative regarding their wishes for the advanced directive. The DNS indicated that the advanced directive form was signed by Resident #48 who was not the decision maker. The DNS indicated that the current code status form signed by the resident is not valid because he was not cognitively intact. The DNS indicated that Resident #48 was a full code from 24 hours after admission until the resident representative signs the advanced directive form. Interview with case manager (LPN #1) on 5/6/24 at 10:04 AM indicated that she was responsible to coordinate the care conferences. LPN #1 indicated that she had conducted the first care conference for Resident #48 on 4/25/24 with Resident #48, resident representative, and another family member. LPN #1 indicated that she does not bring the paper chart into the conference she just goes by the physician orders in the electronic medical record to review at the meeting. LPN #1 indicated she nor anyone else asked the resident representative to sign any forms although the resident's representative was responsible to sign all legal forms. Resident #48 was not able to sign any legal forms with a BIMS of 2. LPN #1 indicated that the code status should be signed at admission and that her first care conference was held between day 14-21 from admission. LPN #1 indicated that she sees the resident representative in the facility visiting every day that she works. Review of the facility Advanced Directive Policy identified it was the policy of the facility to provide each resident with appropriate high quality medical and nursing care. The facility recognizes the right of each resident, if capable, to make decisions regarding his/her treatment and to execute advanced directives. The resident who is not capable to make decisions will have a resident representative on their behalf make the decision for the advanced directive. At the time of admission, the facility will provide each resident or resident representative with a copy of the policy regarding advanced directives. The facility will abide by the decision made by the resident or resident representative with the respect to order a do not resuscitate and the withholding and withdrawal of life sustaining measures. Such decisions made, and consent documented in accordance with facility procedures.

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	05/22/2024

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43032 Based on observation, review of facility documentation, and interviews, the facility failed to maintain a homelike environment as a call bell system malfunction resulted in call bells ringing in 2 of 3 units throughout the facility for several days. The findings include: Observations on 5/6/24 at 1:40 PM identified continuous call bell ringing on the North unit. Interview with LPN #4 on 5/6/24 at approximately 1:40 PM identified the call bell system sound was malfunctioning. She identified the call bell system began malfunctioning on Friday 5/3/24 and continued to malfunction. An interview and review of an e-mail from the Maintenace Director dated 5/2/24 with the Principal Partner, Administrator, Maintenance Director, and Clinical Nurse Consultant on 5/6/24 at 3:00 PM, identified the call bell system on both the North Wing and East Wing nurse's station continuously rang keeping residents from sleeping and annoyed staff. The email further identified an adapter that arrived on Friday 5/3/24 was installed by the Maintenance Director and failed to resolve the problem and he attempted to notify the vendor of the continued problem. The Maintenance Director further indicated the vendor returned the call, however the vendor had left for the day; as the call bells continued to ring over the weekend (5/4/24-5/5/24). The Administrator acknowledged the call bell system malfunctioned on 2 of 3 units, and agreed with the Maintenance Director the vendor would be contacted again for an immediate resolution. Review of the facility April 2014 policy titled Noise Control identified resident care and services should be provided in a manner that promotes calm. organized and comfortable sound levels.

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	05/22/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on record review and interview for 1 of 1 residents (Resident #80) reviewed for Activities of daily living, the facility failed to provide the necessary care and services to maintain or improve mobility. The findings include: Resident #80 was admitted to the facility with diagnoses that included falls, hip replacement, and chronic pain. The care plan dated 12/12/23 identified decreased functional activity. Interventions included to ambulate Resident #80 150 feet with rolling walker and minimal assistance. The annual MDS assessment dated [DATE] identified Resident #80 had intact cognition and needs assistance for transfers and ambulation with a walker. Review of the physician orders dated 3/1/24-5/5/24 directed to ambulate Resident #80 150 feet with rolling walker with assist x 1 twice a day with a wheelchair to follow. Review of the progress notes dated 3/1/24-5/5/24 did not reflect Resident #80 had refused to ambulate or that the APRN /physician were notified that Resident #80 was not being ambulated per physician orders. Review of the 3/1/24 to 3/31/24 nursing assistant flow sheets for Resident #80 identified there were 34 out of 62 opportunities that Resident #80 was not ambulated. Six (6) opportunities for ambulation were not documented, and 28 out of 62 opportunities identified Resident #80 did not ambulate with no rational. Review of the 4/1/24 to 4/30/24 nursing assistant flow sheets for Resident #80 identified there were 25 out of 60 opportunities that Resident #80 was not ambulated. Eleven (11) opportunities for ambulation were not documented, and 14 out of 60 opportunities identified Resident #80 did not ambulate with no rational. Review of the 5/1/24 to 5/5/24 nursing assistant flow sheets for Resident #80 identified there were 7 out of 12 opportunities that Resident #80 was not ambulated. One (1) opportunity for ambulation that was not documented, and 6 out of 12 opportunities that identified Resident #80 did not ambulate with no rational. During an interview on 5/5/24 at 12:36 PM Resident #80 indicated the nursing staff are supposed to walk him/her in the hallway every day twice a day, but that does not happen. Resident #80 indicated that sometimes the therapist will walk him/her to the recreation room for a program, but they are not walking me every day. Resident #80 indicated that he/she was supposed to ambulate two times a day with staff, and it does not occur. Resident #80 indicated that the nursing staff are in a hurry and don't have time to ambulate him/her all the time. Resident #80 indicated that he/she has brought this concern to nursing staff, but nothing has changed. Resident #80 indicated that he/she really wants to be ambulated 2 times a day so he/she can get stronger to be independent and go home. (continued on next page)

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	05/22/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Rehabilitation Department on 5/6/24 at 3:10 PM indicated that each therapist puts in a physician order for nursing to continue with ambulating the residents while on therapy or when coming off therapy. The Director of Rehab indicated that Resident #80 is being seen by therapy 3 times a week privately. The Director of Rehab indicated that therapy had put in a physician's order for the physician to sign off on and the order for Resident #80 was to ambulate with someone from nursing 2 times a day up to 150 feet with a rolling walker and the wheelchair to follow. S/he indicated that nursing was responsible to document how far and how many times Resident #80 ambulates and that no one had reported to her that Resident #80 was not being ambulated by nursing twice a day as ordered by the physician. Interview with NA #2 on 5/7/24 at 8:16 AM indicated that she works 6:00 AM to 2:00 PM full time 4 days a week and she was Resident #80's regular nursing assistant. NA #2 indicated that when she gets done washing Resident #80 in the morning the therapy people take Resident #80 for a couple of hours to therapy. NA #2 indicated after lunch Resident #80 usually goes to recreation, so she does not offer to ambulate Resident #80. NA #2 indicate that she does not inform the charge nurses that he does not ambulate Resident #80 on the days that she works. Interview with the DNS and Administrator on 5/7/24 at 9:23 AM indicated if there was a physician order to ambulate Resident #80 twice a day their expectation was that the nursing staff would ambulate Resident #80 twice a day. The DNS indicated that the nursing assistants would document if they ambulate Resident #80 and document the number of feet ambulated. The DNS expectation is if a resident refuses or does not get walked the nursing assistant must tell the charge nurse. The DNS indicated that if the nursing staff are not following the physician's order the physician must be notified. The Administrator indicated that the resident should ambulate per the physician's order. Interview with APRN #2 on 5/7/24 at 11:15 AM indicated that Resident #80 has a physician order to ambulate two times a day and that her expectation was if Resident #80 was not walked for one day she would want to be notified. APRN #2 indicated she would expect to be notified because she would be able to monitor if there were refusals versus if the nursing staff just were not ambulating Resident #80 and to see if the resident had a decline. APRN #2 indicated that no one had notified her since she started in February 2024 that Resident #80 had not been ambulated.

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	05/22/2024

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 47457 Based on review of facility documentation, facility policy, and interviews for 2 of 6 certified nurse aide personnel files (NA #3 and NA #4), the facility failed to complete performance reviews, annually. Review of NA #4's personnel filed identified that she was hired on 6/13/1995 and failed to identify documentation that an annual performance review was completed for the year of 2023. NA #4's personnel file further identified her last documented employee performance review was dated 6/13/22. Review of NA #3's personnel filed identified that she was hired on 6/14/22 and failed to identify documentation that an annual performance review was completed for the year of 2023. Interview and review of facility documentation with the Director of Human Resources (HR) on 5/7/24 at 6:50 AM identified that the facility was undergoing a process change for completing annual evaluations last summer, and during that time-period a couple evaluations were missed. The Director of HR failed to provide documentation that NA #3 and NA #4 had received an annual performance review in 2023, around the time of their anniversary hire dates or after the facility identified staff members had missed their annual evaluation. Interview with the Administrator on 5/7/24 at 1:10 PM identified that the expectation is that annual evaluations are to be completed within a month of the employee's anniversary of hire date. Interview with the Director of Nursing (DNS) on 5/7/24 at 1:38 PM identified that she was not the DNS during the time that the annual evaluations were missed, and during her time as the DNS she has completed nurse and nurse aide annual evaluations around the employee's anniversary of hire date. The DNS further identified that the evaluation process for nurse and nurse aides is as follows: the Director of HR will notify her whose annual evaluations are due for the upcoming month; once the evaluation is completed, she will return it to the Director of HR to be placed in the individual personnel file. The facility's Performance Evaluation policy directs that employees receive an annual review to measure their position goals, provide constructive feedback, and coach for professional growth. Performance evaluations are conducted at the following intervals: annually on or about the anniversary of hire/rehire date and interim at the discretion of management.

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	05/22/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on record review and interviews for 1 of 5 residents (Resident #48) reviewed for unnecessary medications, the facility failed to ensure behavior monitoring was conducted for a resident on antipsychotic medications. The findings include: Resident #48 was admitted to the facility on [DATE] with diagnoses that included dementia, femur fracture, and depression. A physician's order dated 4/11/24 directed to give Seroquel (antipsychotic/mood stabilizer medication) 25 mg once a day and Seroquel 50mg at bedtime. The admission MDS assessment dated [DATE] identified Resident #48 had severely impaired cognition and required total assistance dressing, toileting, bed mobility, and transfers. Additionally, Resident #48 had a diagnosis of dementia and was taking antipsychotic medications on a routine daily basis and a gradual dose reduction was not attempted. The care plan dated 4/18/24 identified Resident #48 was utilizing antipsychotic medications. Interventions directed to administer medications per physician orders, observe for behaviors, observe for therapeutic effects of medication, and observe for adverse drug related to signs and symptoms. The Pharmacy Consultation Report to the Prescriber for Resident #48 dated 4/29/24 recommended to please update the current antipsychotic order, with a diagnosis, to include a specific behavior that can be quantitative and objectively documented by the nursing staff. The behavior must cause the resident to be a danger to themselves and/or others including staff or actually interfere with the staff's ability to provide care. The following are adequate reasons for use if documented causing impairment in function capacity: psychotic symptoms such as hallucinations, paranoid, delusions, and/or continuous crying out, screaming, yelling, or pacing. The APRN #4 replied on 5/2/24 that the medication was for dementia with insomnia at home and resident representative did not want medications changed. Interview with psychiatric APRN #4 on 5/6/24 at 9:40 AM indicated that when she replied to the pharmacy recommendation on 5/2/24, she had used the psychiatric physicians note dated 4/12/24 that documented he had spoken to the resident representative who discussed the medications taken at home and did not want them changed. APRN #4 indicated that Resident #48 had a daytime dose of Seroquel and a nighttime dose that she had written should be monitored for anxiety. APRN #4 indicated that for Resident #48's antipsychotic at bedtime there must be monitoring for severe insomnia, severe agitation, and yelling out behaviors. APRN #4 indicated that the behavior monitoring orders are to be put in on admission when someone was admitted from the hospital on antipsychotics by nursing for the use of antipsychotics. APRN #4 indicated that it was nursing's responsibility to make sure the behavior monitoring flow sheets were being put in place and the resident was being monitored because the APRN/MD does not write orders for the behavior monitoring. (continued on next page)

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	05/22/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 5/6/24 at 10:39 AM indicated that all antipsychotic medications must have behavior monitoring flow sheets. The DNS indicated the targeted behavior that would be put in place on admission for Resident #48 would come from the behaviors documented on the hospital record, family history, and observed behaviors. The DNS indicated that the nurse supervisor was responsible to make sure the behavior monitoring was put in on admission. After clinical record review, the DNS indicated that the behavior monitoring was not on the physician orders, medication administration record, or the treatment record. The DNS indicated that there should have been behavior monitoring for the Seroquel from admission but indicated she did not know why it was not done. The DNS indicated that she would make sure a behavior monitoring flow sheet was put in place. Review of the facility Use of Psychotropic Medications Policy identified residents are not given psychotropic medications unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Residents will have targeted behavior monitoring for psychotropic medications. Residents who use psychotropic drugs shall also receive non-pharma logical interventions to facilitate reduction or discontinuation of the psychotropic medications.