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	03/16/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, review of facility documentation and interviews, the facility failed to ensure the facility had a process for reconciliation of controlled medications. The findings include:Interview with the ADNS on 3/16/26 at 11:42 AM identified she was responsible for completing the bi-weekly (once every two weeks) controlled medication audits in the facility. Interview with the ADNS on 3/16/26 at 2:07 PM identified her process for the bi-weekly auditing consists of completing a controlled medication count at each of the medication carts with another nurse for verification. The ADNS indicated that when a controlled medication is received, the white controlled medication disposition record (CSDR) is placed with the medication cart with the medication and the yellow copy of the CSDR is placed in a binder located in the ADNS's office. The ADNS further noted that she does not take the binders with the yellow CSDRs with her for the audits. She indicated that she matched the white CSDRs with the yellow CSDRs when the medications are completed or destroyed. The ADNS identified that she was trained to do the audits by the previous DNS and could not identify if the facility had a policy addressing the reconciliation process for controlled medications. The process that the ADNS described does not address how the facility will monitor for the possibility of the diversion (theft) of controlled medications. Observation of the binders containing the yellow CSDRs on 3/16/26 at 2:15 PM identified yellow CSDRs that dated back to 11/21/23. 23 yellow CSDRs with dates from November 2023 through January 2026 were flagged for reconciliation. Interview with the DNS on 3/16/26 at 2:30 PM identified she was responsible for the controlled medication audits but that this process was delegated to the ADNS. The DNS indicated that the ADNS had the responsibility prior to her becoming the DNS and was not aware of the process that was being followed. Interview with the Corporate Representative for Clinical Services and the Administrator on 3/16/2026 at 3:10 PM identified the facility did not have a policy for the controlled medication audits and reconciliation or anything that directs how to do the audits. Interview with the ADNS on 3/16/26 at 4:15 PM identified she was able to reconcile 22 of the 23 flagged controlled medications and could not determine what happened to the Tramadol HCL 50mg (half tablets 25 mg) Quantity of 15 or 30 1/2 tablets received on 11/23/23. The facility did not have a policy that addressed the reconciliation of controlled medications to prevent the possibility of drug diversion.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, review of facility documentation, review of facility policy, and interviews during a review of the Infection Control Program, the facility failed to ensure that the laundry room had a cleaning schedule to protect linens from dust and soil, the facility failed to ensure infection surveillance data collection reports and analysis of infection trends within the facility were completed monthly, the facility failed to ensure the MDRO tracking sheet accurately reflects residents MDRO infection status, and the facility failed to ensure outbreaks were tracked and exposure investigations completed per facility policy. The findings include: During a tour of the laundry room on 3/10/26 at 10:30 AM with the Laundry Supervisor, Laundry Attendant #1 and Laundry Attendant #2 the following was identified: Three washers were noted to be heavily coated with greyish dust-like matter on the top and the sides.The walls behind the washers, pipes and plumbing fixtures connected to all three washers were noted to be heavily coated with greyish dust-like matter as the washers were in use.The laundry detergent system area with tubes connected and supplying the washers with detergent noted to be heavily coated with a whiteish dust-like matter while the washer was in use. Each of the three washers were in use and contained two filters locating on the left side and front facing towards the back of the washers, identified each filter to be covered with a thick coating of greyish dust-like matter, with a sign below each filter along with an arrow pointing towards the filter which read to clean filter daily.Four ceiling lights in the solid laundry area heavily coated with a thick coating of whiteish dust-like matter.Four ceiling lights in the clean area heavily coated with a thick coating of whiteish dust-like matter over uncovered clean linen A heating/cooling wall unit above the window heavily coated with a thick coating of whiteish dust-like matter over uncovered clean linen A metal fan which is extended down from the ceiling with the blades on the fan itself was coated with a greyish dust-like matter. Interview with the Laundry Attendant #1 and #2 on 3/10/26 on 10:30 AM identified they don't have a cleaning schedule for cleaning of the laundry room. Laundry Attendant #2 identified that she sanitizes the outside of the dryers, empty the lint trays in the dryer and clean the floor daily. Interview with the Laundry Supervisor on 3/10/26 at 10:35 AM identified she became the supervisor for the laundry three months ago and there is no actual cleaning schedule for the laundry room, their practice is to clean the laundry room daily. She further identified she was unable to locate any prior cleaning schedules before she started working as the supervisor. She identified there is another Laundry Attendant who is currently out who cleaned the filters on the washers, and she does not know how often it should be cleaned because it was done by the staff person who is current out of work for almost two weeks. She further identified that they should have a cleaning schedule but had not gotten around developing a cleaning schedule since she started working as the supervisor. The Laundry Supervisor identified the staff are responsible for the dusting as they have a duster with an extended head which can be used to clean the ceiling lights, pipes, fans, cooling system on the wall, but the metal fan is done by the maintenance department as it requires the use of a ladder in order to reach it for cleaning. Interview on 3/13/26 at 10:11 AM with the ADNS (overseeing the Infection Control Program) and RN #4 identified the laundry room, especially in the clean linen area, should not have dust as the dust particles could fall on the linens and could cause respiratory illnesses and allergies. A request for a laundry cleaning policy was made but not provided. In an interview with the Laundry Supervisor on 3/13/26 at 9:38 AM identified she does not have such a policy, but it is the practice that the laundry is cleaned daily and has created a laundry cleaning schedule subsequently to the inquiry and observations. Review of the infection control program for the period of June 2024 to February 2026 with the Infection Preventionist in training (RN #4), the ADNS who oversees the program and RN #5 (who is currently mentoring RN #4) on 3/11/26 at 1:09 PM failed to provide documentation that identifies monthly surveillance infection reports were completed for the period of June 2024 through April 2025 and for the period of January 2026 through February 2026. In addition, the facility failed provided documentation that identifies monthly analysis (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of infection trends/rates for the period of October 2024 through April 2025 and for the period of January 2026 through February 2026. Interview on 3/11/26 at 1:09 PM with RN #5 in the presence of the ADNS and RN #4 identified infection surveillance and analysis is completed monthly by the Infection Preventionist (IP) nurse. He identified that the IP nurse's role as it relates to the surveillance is to check if the nurse on the unit completes the infection screening in the evaluation section of the electronic medication records when an infection is suspected and if it is not completed the IP would then complete the screening. After the infection screening evaluation is completed, it will then trigger on the infection board for the IP nurse to review and complete any missing information. He further identified the facility uses McGeer's criteria (a standardized tool used to define an infection) which is automatically built into the computer system to identify if the infection meets criteria immediately. RN #5 identified that at the end of each month he obtains a report from the electronic medical record system, which provides numbers and percentages that he then reviews to check for accuracy and trends. After which, he completes a report which provides the rate of infection based on the type of infection, unit, how it was acquired, precautions, and antibiotics. He noted that he then uses a graph to show month to month trends, and when the trends are identified he figures out the cause of the trend to implement the appropriate interventions which are documented in the report along with the rates. He identified that he had RN #4 come to his facility where he showed her what needed to be completed. The ADNS and RN #4 identified that what RN #5 explained is what should be done; however, it is not being done. RN #4 identified she had printed the report for January 2026 and after visiting RN #5 in late February 2026 she had started to review the report as there was missing and incomplete information causing an inaccurate rate of infections. The ADNS identified that she is new to the role of overseeing RN #4 as she had only started in January of 2026 and is not familiar with the facility's infection practice and policies and is learning as well.Interview on 3/13/26 at 10:11 AM with the ADNS and RN #4 identified they were unable to locate any documentation of monthly infection surveillance that was completed for June 2024 through April 2025 and for the period of January 2026 through February 2026, and monthly analysis of infection trends/rates for the period of October 2024 through April 2025 and for the period of January 2026 through February 2026. Interview with the ADNS and RN #4 on 3/16/25 at 12:25 PM identifies RN #4 provided an Infection Surveillance Report obtained from the electronic medical record system for the period of March 13, 2024, through December 31, 2024, which was incomplete and only contained information from March 2024 through September 2024. RN #4 identified it had incomplete information in various columns such as: sign and symptoms, infection, pharmacy order, and comments, as it is not completed based on how RN #5 explained the reports should be completed. Review of the Infection Surveillance policy identifies the infection preventionist serve as the leader in surveillance activities. The policy further identifies the facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: the data to be collected, including how often and the type of data to be documented including: the infection site, pathogen (if available), signs and symptoms, residents location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections and the identification of unusual or unexpected outcomes, infection trends and patterns. The policy also identifies monthly time periods will be used for capturing and reporting data, line charts will be used to show data comparisons over time and will be monitored for trends. Review of the MDRO Tracking Sheet for the period of June 2024 to February 2026 with the Infection Preventionist in training (RN #4), the ADNS who oversees the program and RN #5 (who is currently mentoring RN #4) on 3/11/26 at 1:09 PM failed to identify the current MDRO infection status of residents within the facility. Reviewing the tracking sheet provided by the facility with the ADNS and RN #4 identified for the year 2026 the tracking sheet indicated that the facility only has 3 residents with MDRO, and the sheet also included each resident site of infection, type of MDRO, antibiotic treatment and isolation type. The ADNS identified the list provided are resident who had an MDRO that was treated in the facility. The ADNS identified there are at least (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 other residents that should have been added to the list who have a history of a MDRO. The ADNS identified that she was unable to locate a MDRO tracking sheet for 2024 and that the MDRO tracking sheet needed to include residents with both active and colonized MDRO infection, and the list should be updated when the resident status changes from active to colonized and whether the resident still resides in the facility. Review of the MDRO Infection policy identified the facility implements facility-wide strategies for preventing the spread of infections with multidrug-resistant organisms. Review of the State Survey Agency's reporting system identified the facility reported an influenza outbreak on 12/15/26. Further review of the outbreak reported identified on the line list identified one resident affected 1/13/26, another resident on 1/16/26 along with 3 staff members who tested positive for influenza on 1/16/26, 2/17/26 and 2/20/26. Review of the infection control program with the Infection Preventionist in training (RN #4), the ADNS who oversees the program and RN #5 (who is currently mentoring RN #4) on 3/11/26 at 1:09 PM identified the facility last outbreak was influenza which was initiated on January 19, 2026 involving one resident, as the other resident was community acquired and it was reported to the State Survey Agency by the DNS. RN #4 identified she was unaware of the staff members who were positive and the ADNS identified she was only aware of one staff member. They identified when a positive case is identified contact tracing or an exposure investigation should be initiated to prevent the spread, however it was not completed as they were not aware of the staff members who tested positive for the influenza virus. Interview with the DNS on 3/11/26 at 1:50 PM identified she was responsible for reporting outbreaks to the State Agency and updating the agency when there are new cases and when the outbreak is closed with a summary. The DNS identified she had kept adding the new cases to the already opened outbreak for influenza and could not recall informing the ADNS and RN #4 of the other positive cases. The DNS identified they should have been informed so that the exposure investigation could have been completed. Review of the Infection Outbreak Response and Investigation policy the facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens and prevent additional infections. The policy further identified a line list about each person affected by the outbreak will be maintained.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation, review of facility policy, and interviews, the facility failed to have a consistent designated Infection Preventionist (IP) with the required specialized training in infection control, that was responsible for the facility's Infection Control Program in 2024, 2025 and 2026. The findings include:Interview with the ADNS and RN #4 on [DATE] at 1:09 PM identified RN #4 was hired as the full time Infection Preventionist nurse for the facility in [DATE] and she is currently completing the specialized Infection Preventionist training course for nursing homes to receive her certification. The ADNS identified she had only been responsible for overseeing the infection control program in [DATE] and had completed all the modules for the Infection Preventionist specialized training in the year 2020 and will provide the certificate. A request was made on [DATE] for the previous Infection Preventionist (IP) nurse certification. The facility provided on [DATE] a list of IP nurses who worked as the IP in the building from [DATE] to [DATE]. The document identified LPN #11 had a certificate that indicated she had completed the IP training course on [DATE] and worked at the facility as the Infection Preventionist from [DATE] through [DATE]; RN #8 had a certificate that indicated she had completed the IP training course on [DATE] and worked at the facility as the IP nurse from [DATE] through [DATE] and RN #9 had a certificate that indicated she had completed the IP training course on [DATE] and worked as the IP nurse from [DATE] through [DATE]. The document provided failed to identify that the facility had an Infection Preventionist who had received specialized training certification working at the facility for the periods from [DATE] through April of 2025, and from [DATE] through [DATE]. Review of the infection control program on [DATE] at 10:11 AM with the ADNS and RN #4 failed to identify a MDRO tracking list for the year 2024, unable to provide any documentation that monthly infection surveillance and analysis of infections in the facility and antibiotic stewardship surveillance were completed for the period of [DATE] through [DATE], in complete documentation for [DATE], and for the period of [DATE] to February 2026. The ADNS identified the IP nurse was responsible for ensuring the infection surveillance and analysis was completed, however the facility had nobody working in the role of the IP nurse during some of the timeframe. Interview and review of the documents and certification on [DATE] at 3:30 PM with the Administrator identified the facility had gaps where the facility had no Infection Preventionist nurse and they were unable to find someone to fill the position. She further identified that the facility had job posting for the position and they were doing the best they can. She further identified the former DNS (RN #9) worked as the DNS and would also cover the IP nurse and will get her hire date of the DNS. Interview with the ADNS on [DATE] and RN #4 at 12:25 PM identified she had completed the modules but does not have the certificate of completion as she had done the modules a while now in 2020. The ADNS provided a document that indicated that the end of training plan verification and CE information expired since [DATE], at 11:59 PM. Review of the documents provided and interview with the Administrator on [DATE] at 1:00 PM identified a on the job posting document which indicated that the facility first posted an open position for the Infection Preventionist nurse on [DATE] and had made changes to the posting on various times. The Administrator further identified that the ADNS had completed her training and had the paperwork. The Administrator further identified that RN #9 worked as the DNS from [DATE] through [DATE]. However, the facility failed to provide the certificate that certifies that the ADNS had completed the Nursing Home Infection Preventionist training course, which would include the date the certificate was awarded and the number of contact hours. In addition, the documentation provided by the facility identified that RN #9 did not receive her infection preventionist certification until [DATE] and was working as the DNS prior and after, until [DATE] when she took on the role as the facility's infection preventionist nurse. A request for a policy regarding having a designated Infection Preventionist with specialized training was not provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and interviews for one of three sample residents (Resident #119) reviewed for resident-to-resident sexual abuse, the facility failed to ensure the resident was free from inappropriate sexual conduct. The findings include:Resident #119 had diagnoses that included dementia without behavioral disturbances, anxiety, and depression.The quarterly MDS assessment dated [DATE] identified Resident #119 had severe cognitive impairment, required extensive assistance with toileting, personal hygiene, dressing, and transfers, it further noted the resident utilized a rolling walker and a wheelchair for mobility.The Resident Care Plan (RCP) dated 12/19/25 identified Resident #119 verbalized the desire to be intimate with his/her partner as evidence by kissing and hand holding. The care plan interventions directed to provide psychiatric consultation as indicated, report any changes or concern to the physician, provide a safe and/or private are for intimacy, and one-to-one visits with social worker as needed.The psychiatrist progress note dated 2/19/26 identified Resident #119 was being followed for medication management and behavioral assessment in the context of the diagnoses of dementia and anxiety. The note further identified Resident #119's dementia was progressive but stable and he/she continues to have poor short-term memory, wanders around the facility but has not been exit seeking, is very social and pleasant toward other residents. There is no safety concerns reported.The late entry social worker progress note dated 3/1/26 at 11:30 AM identified that he/she was notified that a resident was observed displaying physical affection toward Resident #119 while in the recreation room. Staff immediately intervened and re-directed both residents. The note further identified that she (social worker) had assessed Resident #119's emotional status following the interaction, and Resident #119 had not exhibited any signs of distress at the time. A follow-up assessment was completed and reinforcement of appropriate boundaries and resident rights. The note further noted that social services would continue to monitor and provide support as needed.Interview with Person #1 (Resident #119's responsible party) on 3/11/26 at 12:10 PM identified that the nursing staff called on 3/1/26 to inform him/her that a resident had touched Resident #119's chest in the recreation room. Person #1 identified that Resident #119 has impaired cognition and often does not recognize him/her during visits. Person #1 described Resident #119 as very social and tactile but emphasized that Resident #119 did not give permission for inappropriate touching of his/her body. Resident #31 had diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, epilepsy, depression, and dysarthria.The annual MDS assessment dated [DATE] identified Resident #31 had intact cognition and required extensive assistance for toileting, personal hygiene, dressing, transfers, and ambulation.The care plan dated 12/6/25 identified Resident #31 had a behavioral problem as evidence by verbal outbursts, yelling at staff, accusatory toward staff, refusing food, medications and fluids. Care plan interventions directed to administer medication as ordered, analyze the key times, places, circumstances, triggers, de-escalate behavior, evaluate, review, and document behavior per protocol. Care plan interventions further noted that Resident #31 preferred to sit alone while in the dining room, and psychiatric follow up as needed.LPN #1's nursing note dated 3/1/26 at 9:04 PM identified that RA #1 reported Resident #31 was in the recreation room alone with Resident #119 while staff were transporting other residents to the recreation room. RA #1 observed Resident #31 touching the breast of Resident #119 when she entered the recreation room. Resident #119 was removed from the recreation room. Resident #31 confirmed that he/she touched Resident #119's breast and had stated that he/she was just an old man and laughed it off. She identified that she educated Resident #31 not to touch other residents because not all residents have the same understanding. The family, the APRN and the Nursing supervisor were made aware of the incident.A late entry social worker progress note written on 3/2/26 for 3/1/26 at 11:30 AM identified that (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #31 perceived the interaction with Resident #119 as mutual. She provided education to Resident #31 regarding appropriate boundaries, consent, and the need to respect the rights and personal space of other residents. Resident #31 verbalized understanding, was receptive to redirection and apologized to SW #1 regarding the incident. The psychiatric progress note dated 3/3/26 identified Resident #31 acknowledged his/her behavior and reported that Resident #119 did not mind. Resident #31 stated it would not happen again and that this was the first such incident. A mental status exam identified Resident #31 was alert, pleasant and cooperative with speech and language within normal limits; thought process coherent, goal directed and insight and judgment fair.Interview with Resident #31 on 3/11/26 at 10:30 AM identified that while seated with Resident #119 in the recreation room, he/she touched Resident #119's breast. Resident #31 identified he/she told Resident #119 that he/she had nice breasts but could not recall whether Resident #119 had given permission to be touched. Interview with LPN #3 on 3/10/26 at 12:25 PM identified that Recreation Aide (RA #1) observed Resident #31 inappropriately touch Resident #119's breast while both residents were seated together in the recreation room on 3/1/26 and immediately reported the incident. She further noted that when questioned, Resident #31 admitted to touching Resident #119's breast. LPN #3 further noted that she provided education to Resident #31 about inappropriate touching and the need to respect boundaries, especially since not all residents can give consent. Additionally, she identified Resident #119 lacked the capacity to consent due to cognitive impairment. LPN #3 noted that she reported the incident to the nursing supervisor and was instructed not to initiate an Accident and Incident (A&I) report but to notify the APRN and the resident's family.Interview with SW #1 on 3/10/26 at 1:10 PM identified that RA #1 notified her via email about inappropriate touching between Resident #31 and Resident #119. SW #1 identified that on 3/1/26, RA #1 observed Resident #31 rubbing Resident #119's breast area in the recreation room and immediately removed Resident #119 from the area. SW #1 identified that she spoke with Resident #31, who believed Resident #119 had given permission to be touched. SW #1 provided education to Resident #31 about respecting personal boundaries and personal space. SW #1 further identified that Resident #119 could not give consent due to impaired cognition.Interview with RN #3 (weekend nursing supervisor) on 3/10/26 at 2:30 PM identified LPN #3 notified her of the incident of inappropriate touching involving Resident #31 and Resident #119. RN #3 identified she had not notified the nursing administration, nor initiated an investigation or filed an A&I report because she did not want to escalate the matter. Interview the Administrator in the presence of the DNS on 3/11/26 at 1:30 PM identified that they had not received any calls from nursing staff regarding a potential sexual abuse incident between Resident #31 and Resident #119 on 3/1/26. They were informed of the incident the next day. The Administrator indicated that when a potential reportable incident occurs, the nursing supervisor, DNS, and Administrator initiate an investigation, obtains statements from staff, and reports the incident to the state survey agency if required. The Administrator reported that she instructed the social worker to speak with both residents. The Administrator further identified that the facility had not investigated the alleged sexual contact between the two residents because Resident #119 has a documented history of seeking physical contact and relationships with other residents and had a care plan in place to address this behavior. She identified that Resident #119 can verbalize needs and wants, and it is the resident's right to decide whether he/she consents to being touched. She further identified that she was unsure whether Resident #119 had been evaluated by the psychiatrist to determine whether the resident could give consent to engage in sexual activity. Interview with RA #1 on 3/12/26 at 1:00 PM identified that on 3/1/26 she observed Resident #31's left hand beneath Resident #119's armpit, rubbing the chest/breast area while both were seated in the recreation room. She identified this was her first time witnessing such behavior and she immediately removed Resident #119 from the recreation room and reported the incident to LPN #3. RA#1 said she was transporting other residents to the recreation room when she observed the incident.The facility Abuse, Neglect and Exploitation policy states that the facility will establish and maintain a safe environment that, to the extent (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible, supports residents' consensual sexual relationships while implementing policies and protocols to prevent sexual abuse. Policies will specify when, how, and by whom determinations of capacity to consent to sexual contact will be made and where those determinations will be documented. The policy will also affirm the resident's right to form and maintain relationships with other individuals.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and interviews for one of three sample residents (Resident #119) reviewed for sexual abuse, the facility failed to report allegation of sexually inappropriate behavior between two residents to the state survey agency. The findings include:Resident #119 had diagnoses that included dementia without behavioral disturbances, anxiety, and depression.The quarterly MDS assessment dated [DATE] identified Resident #119 had severe cognitive impairment, required extensive assistance with toileting, personal hygiene, dressing, and transfers, it further noted the resident utilized a rolling walker and a wheelchair for mobility.The Resident Care Plan (RCP) dated 12/19/25 identified Resident #119 verbalized the desire to be intimate with his/her partner as evidence by kissing and hand holding. The care plan interventions directed to provide psychiatric consultation as indicated, report any changes or concern to the physician, provide a safe and/or private are for intimacy, and one-to-one visits with social worker as needed.The psychiatrist progress note dated 2/19/26 identified Resident #119 was being followed for medication management and behavioral assessment in the context of the diagnoses of dementia and anxiety. The note further identified Resident #119's dementia was progressive but stable and he/she continues to have poor short-term memory, wanders around the facility but has not been exit seeking, is very social and pleasant toward other residents. There is no safety concerns reported.The late entry social worker progress note dated 3/1/26 at 11:30 AM identified that he/she was notified that a resident was observed displaying physical affection toward Resident #119 while in the recreation room. Staff immediately intervened and re-directed both residents. The note further identified that she (social worker) had assessed Resident #119's emotional status following the interaction, and Resident #119 had not exhibited any signs of distress at the time. A follow-up assessment was completed and reinforcement of appropriate boundaries and resident rights. The note further noted that social services would continue to monitor and provide support as needed.Interview with Person #1 (Resident #119's responsible party) on 3/11/26 at 12:10 PM identified that the nursing staff called on 3/1/26 to inform him/her that a resident had touched Resident #119's chest in the recreation room. Person #1 identified that Resident #119 has impaired cognition and often does not recognize him/her during visits. Person #1 described Resident #119 as very social and tactile but emphasized that Resident #119 did not give permission for inappropriate touching of his/her body. Resident #31 had diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, epilepsy, depression, and dysarthria.The annual MDS assessment dated [DATE] identified Resident #31 had intact cognition and required extensive assistance for toileting, personal hygiene, dressing, transfers, and ambulation.The care plan dated 12/6/25 identified Resident #31 had a behavioral problem as evidence by verbal outbursts, yelling at staff, accusatory toward staff, refusing food, medications and fluids. Care plan interventions directed to administer medication as ordered, analyze the key times, places, circumstances, triggers, de-escalate behavior, evaluate, review, and document behavior per protocol. Care plan interventions further noted that Resident #31 preferred to sit alone while in the dining room, and psychiatric follow up as needed.LPN #1's nursing note dated 3/1/26 at 9:04 PM identified that RA #1 reported Resident #31 was in the recreation room alone with Resident #119 while staff were transporting other residents to the recreation room. RA #1 observed Resident #31 touching the breast of Resident #119 when she entered the recreation room. Resident #119 was removed from the recreation room. Resident #31 confirmed that he/she touched Resident #119's breast and had stated that he/she was just an old man and laughed it off. She identified that she educated Resident #31 not to touch other residents because not all residents have the same understanding. The family, the APRN and the Nursing supervisor were made aware of the incident.A late entry social worker progress note written on 3/2/26 for 3/1/26 at 11:30 AM identified (continued on next page)

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	075333	A. Building B. Wing	03/16/2026

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #31 perceived the interaction with Resident #119 as mutual. She provided education to Resident #31 regarding appropriate boundaries, consent, and the need to respect the rights and personal space of other residents. Resident #31 verbalized understanding, was receptive to redirection and apologized to SW #1 regarding the incident. The psychiatric progress note dated 3/3/26 identified Resident #31 acknowledged his/her behavior and reported that Resident #119 did not mind. Resident #31 stated it would not happen again and that this was the first such incident. A mental status exam identified Resident #31 was alert, pleasant and cooperative with speech and language within normal limits; thought process coherent, goal directed and insight and judgment fair.Interview with Resident #31 on 3/11/26 at 10:30 AM identified that while seated with Resident #119 in the recreation room, he/she touched Resident #119's breast. Resident #31 identified he/she told Resident #119 that he/she had nice breasts but could not recall whether Resident #119 had given permission to be touched. Review of the state survey agency's online reporting portal on 3/10/26 at 10:30 AM failed to identify that the facility submitted a reportable event involving inappropriate touching behavior between Resident #31 and Resident #119. The facility failed to report the incident within two hours of the allegation of abuse. Interview with LPN #3 on 3/10/26 at 12:25 PM identified that Recreation Aide (RA #1) observed Resident #31 inappropriately touch Resident #119's breast while both residents were seated together in the recreation room on 3/1/26 and immediately reported the incident. She further noted that when questioned, Resident #31 admitted to touching Resident #119's breast. LPN #3 further noted that she provided education to Resident #31 about inappropriate touching and the need to respect boundaries, especially since not all residents can give consent. Additionally, she identified Resident #119 lacked the capacity to consent due to cognitive impairment. LPN #3 noted that she reported the incident to the nursing supervisor and was instructed not to initiate an Accident and Incident (A&I) report but to notify the APRN and the resident's family.Interview with SW #1 on 3/10/26 at 1:10 PM identified that RA #1 notified her via email about inappropriate touching between Resident #31 and Resident #119. SW #1 identified that on 3/1/26, RA #1 observed Resident #31 rubbing Resident #119's breast area in the recreation room and immediately removed Resident #119 from the area. SW #1 identified that she spoke with Resident #31, who believed Resident #119 had given permission to be touched. SW #1 provided education to Resident #31 about respecting personal boundaries and personal space. SW #1 further identified that Resident #119 could not give consent due to impaired cognition.Interview with RN #3 (weekend nursing supervisor) on 3/10/26 at 2:30 PM identified LPN #3 notified her of the incident of inappropriate touching involving Resident #31 and Resident #119. RN #3 identified she had not notified the nursing administration, nor initiated an investigation or filed an A&I report because she did not want to escalate the matter. Interview the Administrator in the presence of the DNS on 3/11/26 at 1:30 PM identified that they had not received any calls from nursing staff regarding a potential sexual abuse incident between Resident #31 and Resident #119 on 3/1/26. They were informed of the incident the next day. The Administrator indicated that when a potential reportable incident occurs, the nursing supervisor, DNS, and Administrator initiate an investigation, obtains statements from staff, and reports the incident to the state survey agency if required. The Administrator reported that she instructed the social worker to speak with both residents. The Administrator further identified that the facility had not investigated the alleged sexual contact between the two residents because Resident #119 has a documented history of seeking physical contact and relationships with other residents and had a care plan in place to address this behavior. She identified that Resident #119 can verbalize needs and wants, and it is the resident's right to decide whether he/she consents to being touched. She further identified that she was unsure whether Resident #119 had been evaluated by the psychiatrist to determine whether the resident could give consent to engage in sexual activity. After surveyor inquiry regarding the reportable event on 03/11/26, the facility still had not submitted a reportable event through the FLIS online reporting portal, as the Administrator indicated that the incident was not considered a reportable event.Interview with RA #1 on 3/12/26 at 1:00 PM identified (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that on 3/1/26 she observed Resident #31's left hand beneath Resident #119's armpit, rubbing the chest/breast area while both were seated in the recreation room. She identified this was her first time witnessing such behavior and she immediately removed Resident #119 from the recreation room and reported the incident to LPN #3. RA#1 said she was transporting other residents to the recreation room when she observed the incident.The facility Abuse, Neglect, and Exploitation policy requires that all alleged violations be reported to the administrator, state agency, Adult Protective Services, and other required agencies (including law enforcement when applicable) within specified timeframes. Reports must be made immediately but no later than 2 hours after the allegation if the event involves abuse or results in serious bodily injury. If the event does not involve abuse and does not result in serious bodily injury, the report must be made no later than 24 hours after the allegation. The administrator and/or DNS must follow up with the government agency during business hours to confirm receipt of the initial report and must report the final investigation results to the agency within 5 working days of the incident, as required by state agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and interviews for one of three sample residents (Resident #119) reviewed for sexual abuse, the facility failed to conduct a timely and comprehensive investigation involving an inappropriate sexual behavior between two residents and failed to put measures in place to prevent the recurrence of the inappropriate behavior with Resident #119 and other residents. The findings include: Resident #119 had diagnoses that included dementia without behavioral disturbances, anxiety, and depression.The quarterly MDS assessment dated [DATE] identified Resident #119 had severe cognitive impairment, required extensive assistance with toileting, personal hygiene, dressing, and transfers, it further noted the resident utilized a rolling walker and a wheelchair for mobility.The Resident Care Plan (RCP) dated 12/19/25 identified Resident #119 verbalized the desire to be intimate with his/her partner as evidence by kissing and hand holding. The care plan interventions directed to provide psychiatric consultation as indicated, report any changes or concern to the physician, provide a safe and/or private are for intimacy, and one-to-one visits with social worker as needed.The psychiatrist progress note dated 2/19/26 identified Resident #119 was being followed for medication management and behavioral assessment in the context of the diagnoses of dementia and anxiety. The note further identified Resident #119's dementia was progressive but stable and he/she continues to have poor short-term memory, wanders around the facility but has not been exit seeking, is very social and pleasant toward other residents. There is no safety concerns reported.The late entry social worker progress note dated 3/1/26 at 11:30 AM identified that he/she was notified that a resident was observed displaying physical affection toward Resident #119 while in the recreation room. Staff immediately intervened and re-directed both residents. The note further identified that she (social worker) had assessed Resident #119's emotional status following the interaction, and Resident #119 had not exhibited any signs of distress at the time. A follow-up assessment was completed and reinforcement of appropriate boundaries and resident rights. The note further noted that social services would continue to monitor and provide support as needed.Interview with Person #1 (Resident #119's responsible party) on 3/11/26 at 12:10 PM identified that the nursing staff called on 3/1/26 to inform him/her that a resident had touched Resident #119's chest in the recreation room. Person #1 identified that Resident #119 has impaired cognition and often does not recognize him/her during visits. Person #1 described Resident #119 as very social and tactile but emphasized that Resident #119 did not give permission for inappropriate touching of his/her body. Resident #31 had diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, epilepsy, depression, and dysarthria.The annual MDS assessment dated [DATE] identified Resident #31 had intact cognition and required extensive assistance for toileting, personal hygiene, dressing, transfers, and ambulation.The care plan dated 12/6/25 identified Resident #31 had a behavioral problem as evidence by verbal outbursts, yelling at staff, accusatory toward staff, refusing food, medications and fluids. Care plan interventions directed to administer medication as ordered, analyze the key times, places, circumstances, triggers, de-escalate behavior, evaluate, review, and document behavior per protocol. Care plan interventions further noted that Resident #31 preferred to sit alone while in the dining room, and psychiatric follow up as needed.LPN #1's nursing note dated 3/1/26 at 9:04 PM identified that RA #1 reported Resident #31 was in the recreation room alone with Resident #119 while staff were transporting other residents to the recreation room. RA #1 observed Resident #31 touching the breast of Resident #119 when she entered the recreation room. Resident #119 was removed from the recreation room. Resident #31 confirmed that he/she touched Resident #119's breast and had stated that he/she was just an old man and laughed it off. She identified that she educated Resident #31 not to touch other residents because not all residents have the same understanding. The family, the APRN and the Nursing supervisor were made aware of the incident.A late entry social worker progress note (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	written on 3/2/26 for 3/1/26 at 11:30 AM identified that Resident #31 perceived the interaction with Resident #119 as mutual. She provided education to Resident #31 regarding appropriate boundaries, consent, and the need to respect the rights and personal space of other residents. Resident #31 verbalized understanding, was receptive to redirection and apologized to SW #1 regarding the incident. The psychiatric progress note dated 3/3/26 identified Resident #31 acknowledged his/her behavior and reported that Resident #119 did not mind. Resident #31 stated it would not happen again and that this was the first such incident. A mental status exam identified Resident #31 was alert, pleasant and cooperative with speech and language within normal limits; thought process coherent, goal directed and insight and judgment fair.Interview with Resident #31 on 3/11/26 at 10:30 AM identified that while seated with Resident #119 in the recreation room, he/she touched Resident #119's breast. Resident #31 identified he/she told Resident #119 that he/she had nice breasts but could not recall whether Resident #119 had given permission to be touched. Review of the facility's investigation records identified that, although a reportable event investigation was requested on 3/10/26, the facility did not initiate or begin an investigation into the reportable event that occurred on 3/1/26. The facility failed to follow its own abuse policy, which states that the facility will immediately investigate when there is a report of sexual abuse. The policy requires the investigation to include interviews with all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others with relevant information, and must include complete and thorough documentation of findings and actions taken. Review of Resident #31's care plan failed to identify that the care plan had been updated to address the newly developed behavior to ensure other residents were protected from inappropriate touching. Interview with LPN #3 on 3/10/26 at 12:25 PM identified that Recreation Aide (RA #1) observed Resident #31 inappropriately touch Resident #119's breast while both residents were seated together in the recreation room on 3/1/26 and immediately reported the incident. She further noted that when questioned, Resident #31 admitted to touching Resident #119's breast. LPN #3 further noted that she provided education to Resident #31 about inappropriate touching and the need to respect boundaries, especially since not all residents can give consent. Additionally, she identified Resident #119 lacked the capacity to consent due to cognitive impairment. LPN #3 noted that she reported the incident to the nursing supervisor and was instructed not to initiate an Accident and Incident (A&I) report but to notify the APRN and the resident's family.Interview with SW #1 on 3/10/26 at 1:10 PM identified that RA #1 notified her via email about inappropriate touching between Resident #31 and Resident #119. SW #1 identified that on 3/1/26, RA #1 observed Resident #31 rubbing Resident #119's breast area in the recreation room and immediately removed Resident #119 from the area. SW #1 identified that she spoke with Resident #31, who believed Resident #119 had given permission to be touched. SW #1 provided education to Resident #31 about respecting personal boundaries and personal space. SW #1 further identified that Resident #119 could not give consent due to impaired cognition.Interview with RN #3 (weekend nursing supervisor) on 3/10/26 at 2:30 PM identified LPN #3 notified her of the incident of inappropriate touching involving Resident #31 and Resident #119. RN #3 identified she had not notified the nursing administration, nor initiated an investigation or filed an A&I report because she did not want to escalate the matter. Interview the Administrator in the presence of the DNS on 3/11/26 at 1:30 PM identified that they had not received any calls from nursing staff regarding a potential sexual abuse incident between Resident #31 and Resident #119 on 3/1/26. They were informed of the incident the next day. The Administrator indicated that when a potential reportable incident occurs, the nursing supervisor, DNS, and Administrator initiate an investigation, obtains statements from staff, and reports the incident to the state survey agency if required. The Administrator reported that she instructed the social worker to speak with both residents. The Administrator further identified that the facility had not investigated the alleged sexual contact between the two residents because Resident #119 has a documented history of seeking physical contact and relationships with other residents and had a care plan in place to address this behavior. She identified that Resident #119 can (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbalize needs and wants, and it is the resident's right to decide whether he/she consents to being touched. She further identified that she was unsure whether Resident #119 had been evaluated by the psychiatrist to determine whether the resident could give consent to engage in sexual activity. After the surveyor inquiry regarding the reportable event investigation on 3/11/26, the facility did not initiate an investigation, as the Administrator indicated that the incident was not considered a reportable event. Further, the Administrator and the DNS could not identify what measures were put in place to prevent this behavior from recurring with Resident #119 and/or to protect other residents from this behavior. Interview with RA #1 on 3/12/26 at 1:00 PM identified that on 3/1/26 she observed Resident #31's left hand beneath Resident #119's armpit, rubbing the chest/breast area while both were seated in the recreation room. She identified this was her first time witnessing such behavior and she immediately removed Resident #119 from the recreation room and reported the incident to LPN #3. RA#1 said she was transporting other residents to the recreation room when she observed the incident.The facility Abuse, Neglect and Exploitation policy requires an immediate investigation when there is suspicion or a report of abuse, neglect, or exploitation. The investigation must identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and any others with relevant knowledge, and must include complete, thorough documentation of findings and actions taken.

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F 0686 Level of Harm - Minimal harm or potential for 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 observation, review of clinical records, review of facility policy review, and staff interviews for two of three sampled residents (Resident #20 and #115) reviewed for facility acquired pressure ulcers, the facility failed to ensure that Braden Scale assessments were completed in accordance with the facility's policy, documentation of turning and repositioning, failed to ensure that a comprehensive pressure ulcer assessment was completed once the pressure ulcer was identified and failed to ensure timely treatment orders were put in place. The findings include:Resident #115 was re-admitted to the facility on [DATE] with diagnoses that included peripheral venous insufficiency, pneumonia, anemia, chronic venous hypertension with other complication of bilateral lower extremity. The Braden Scale assessment (used to predict the risk of pressure ulcer development) dated 8/5/25 identified Resident #115 had a score of 16 which indicate a low risk to develop a pressure ulcer. The physician's order dated 8/5/25 directed staff to apply skin prep to both heels twice daily, with instructions to observe for discoloration, pain, or any open areas, and to notify the physician of any changes. The order also directed staff to ensure the resident was turned and repositioned every two hours and that a pressureˆreducing mattress was in place whenever the resident was lying in bed. The Resident Care Plan (RCP) dated 9/2/25 identified that Resident #115 had an alteration in skin integrity related to moistureˆassociated skin damage. The care plan interventions included repositioning the resident every two hours, administering treatments as ordered by the physician, providing incontinence care every two hours, and applying barrier cream as needed. The quarterly MDS assessment dated [DATE] identified that Resident #115 had severe cognitive impairment and required extensive assistance with toileting, personal hygiene, dressing, and transfers, and was nonˆambulatory. The assessment further indicated that the resident had an indwelling catheter, was always incontinent of bowel, and was at risk for the development of pressure ulcers but had no pressure ulcers at that time. Review of Resident #115's clinical record identified that the required quarterly Braden Scale assessment had not been completed. The Braden Scale assessment should have been completed prior to the quarterly MDS assessment dated [DATE]. The quarterly MDS assessment dated [DATE] identified that Resident #115 had severe cognitive impairment and required extensive assistance with toileting, personal hygiene, dressing, and transfers, and was nonˆambulatory. The assessment further indicated that the resident had an indwelling catheter, was always incontinent of bowel, and was at risk for the development of pressure ulcers but had no pressure ulcers at that time. Review of Resident #115's clinical record identified that the required quarterly Braden Scale assessment had not been completed. The Braden Scale assessment should have been completed prior to the quarterly MDS assessment dated [DATE]. The nurse's notes dated 1/15/26 at 5:30 PM identified that Resident #115 was noted to have an open wound on the left heel. The resident denied pain or discomfort. The APRN and the resident's family were notified of the open wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's orders dated 1/15/26 directed staff to cleanse the left heel with normal saline, applied calcium alginate to the wound bed and cover with dry clean dressing daily and as needed when soiled and/or dislodged. Staff had also been directed to offload both heels. The RN #2 (wound nurse) wound assessment dated [DATE] identified that Resident #115 had an open wound to the left heel, which had been classified as a pressure wound. The treatment plan directed staff to cleanse the left heel with normal saline, apply calcium alginate, cover with a dry clean dressing daily, and offˆload the heels. The wound assessment failed to identify the wound measurement, a description of the wound bed, and/or the stage of the left heel pressure injury. The initial physician's wound consultation dated 1/22/26 identified that Resident #115's left heel wound was evaluated and identified as a Stage 3 pressure injury. The wound was measured as 3.5 centimeters in length, 3.0 centimeters in width, and 0.1 centimeters in depth. The wound base was described as consisting of 25% epithelial tissue, 25% granulation tissue, and 50% eschar. The treatment plan directed staff to cleanse the wound with normal saline, apply Santyl (a chemical debridement agent), followed by calcium alginate to the wound base, and secure with a dry, clean dressing twice daily. The weekly wound physician's progress notes dated 1/29/26 indicated that Resident #115's left heel wound was reclassified as an unstageable pressure injury. The wound measured 4.4 centimeters in length and 4.0 centimeters in width. The wound base was described as consisting of 50% slough and 50% eschar. The treatment plan directed staff to cleanse the wound with normal saline, apply Santyl (a chemical debridement agent), followed by calcium alginate to the wound base, and secure with a dry, clean dressing twice daily. The nurse's notes dated 2/13/26 at 9:39 PM identified that Resident #115 had an Xˆray of the left foot, which showed no evidence of osteomyelitis or fracture. Arthritis was noted in the left foot. The duplex scan of the left lower extremity, dated 2/28/26, showed decreased velocity in the left dorsalis pedis artery and moderate stenosis in the left lower extremity. This test is a nonˆinvasive diagnostic procedure used to visualize blood vessels and measure blood flow. The vascular consultation dated 3/5/26 indicated that Resident #115 had a left heel wound and hazy plaque throughout the arteries of the left leg. The consultation recommended that the resident undergo an angioplasty procedure (a minimally invasive, nonˆsurgical procedure used to open a narrowed or blocked blood vessel to restore proper blood flow) and continue offloading the heels. The weekly wound physician's progress notes dated 3/12/26 identified that Resident #115's left heel wound was reclassified as an arterial, fullˆthickness wound. The wound measured 4.5 centimeters in length and 4.5 centimeters in width. The wound base was described as consisting of 25% to 49% granulation tissue, 25% to 49% slough, and 24% eschar. The treatment plan directed staff to cleanse the wound with normal saline, apply Santyl (a chemical debridement agent), followed by calcium alginate to the wound base, and secure with a dry, clean dressing twice daily. The vascular consultation dated 3/13/26 indicated that Resident #115 underwent a left superficial femoral artery angioplasty due to stenosis of the left femoral and tibial arteries. Observation on 3/16/26 at 8:35 AM identified Resident #115 was observed lying in bed on a low airˆloss mattress with both heels floated using a blue foam heelˆoffloading device. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of wound care with LPN #2 and RN #2 on 3/16/26 at 10:40 AM identified Resident #115 was observed lying in bed on a low airˆloss mattress with both heels floated using a blue foam heelˆoffloading device. The resident had an open wound on the left heel. The wound bed contained black necrotic (dead) tissue and yellow slough (dead) tissue. Interview with RN #2 (wound nurse) on 3/11/26 at 2:45 PM identified that she had been responsible for monitoring all residents' wounds on a weekly basis and for assisting the wound specialist physician during weekly wound rounds. She reported that the charge nurse had notified her on 1/16/26, that Resident #115 had developed an open wound on the left heel. She identified that she had assessed the resident's left heel wound, obtained a treatment order from the APRN, and added the resident to the list for the next wound round with the wound specialist. She acknowledged that she had forgotten to measure the wound and to provide a description of the wound at the time it was reported. She further identified that she does not stage any open wounds until the wound specialist has evaluated and staged them Interview with the DNS on 3/16/26 at 9:00 AM identified that the charge nurse and/or the nursing supervisor is responsible for assessing residents for risk of pressure ulcers. She explained that the facility uses the Braden Scale to determine whether a resident is at risk for pressure ulcer development. She reported that, per facility policy, Braden Scale assessments must be completed upon admission or admission, weekly for four weeks following admission/readmission, quarterly, and whenever a resident experiences a significant change in condition. The DNS identified that when a resident is identified as being at risk for pressure ulcers, the facility initiates interventions such as barrier cream, skin prep, pressureˆreducing mattresses, and a twoˆhour turning and positioning schedule, depending on the location and nature of the risk. She reported that she could not attest to whether Resident #115's Braden Scale assessments were accurate because the scoring depends on the resident's clinical presentation at the time each question on the Braden Scale is answered. Interview with MD #1 (wound specialist) on 3/16/26 at 11:55 AM identified that he evaluated Resident #115's left heel wound on 1/22/26 during his scheduled woundˆconsultation visit. He reported that, at the time of his initial assessment, the left heel wound was pressureˆrelated. He further explained that the resident's left leg arterial stenosis, which was confirmed by a duplex scan and subsequently treated with an angioplasty procedure, contributed to the rapid deterioration and/or delayed healing of the wound. He identified that Resident #115's left heel wound may have a mixed etiology, related both to pressure and to the arterial stenosis of the left leg. The facility Pressure Injury Prevention and Management policy identified the facility's commitment to preventing avoidable pressure injuries unless clinically unavoidable and to providing treatment and services aimed at healing existing pressure injuries, preventing infection, and preventing the development of additional pressure injuries. The policy directed licensed nurses to conduct a pressureˆinjury risk assessment using the Braden Scale upon admission or readmission, weekly for four weeks thereafter, quarterly, and whenever the resident experienced a change in condition. The policy also indicated that the facility would complete a thorough assessment and evaluation of the wound, and that the interdisciplinary team would develop a relevant care plan with appropriate interventions Resident #20's diagnoses include vascular dementia without behavioral disturbance, cachexia, non-thrombocytopenic purpura, osteoarthritis and left artificial hip joint. The quarterly MDS assessment dated [DATE] identified Resident #20 had severely impaired (continued on next page)

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Manchester Rehabilitation and Healthcare Center	385 W Center St Manchester, CT 06040

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition, was incontinent of bowel and bladder, was at risk for developing pressure ulcers/injuries, had a skin tear and was receiving hospice care. The care plan dated 11/18/25 identified Resident #20 had the potential for alteration in skin integrity related to decreased mobility, incontinence, and diagnosis of purpura, with interventions that include: incontinent care every two hours and as needed, pressure redistribution device to seat of device when out of bed and pressure redistribution mattress and repositioning every two hours The active monthly physician's orders for December 2025 identified Resident #20 was non-ambulatory and directed weekly skin checks every Tuesday, apply moisture barrier cream to bilateral buttocks and coccyx every shift for breakdown prevention, monitor buttocks for skin breakdown and apply Desitin every shift. The weekly skin check documentation dated 1/6/26 identified a new skin impairment located on the left gluteal fold. It further noted that the nursing supervisor and the wound care nurse were notified. A review of the clinical record failed to identify that the newly found skin wound was assessed by a registered nurse when the skin impairment was noted on 1/6/26. According to the National Institute of Health, a comprehensive assessment of a pressure wound should include staging with the depth, length and width noted along with the notation of location, any exudate, a description of what the tissue looks like, any odors and if any undermining or tunneling is present. This documentation should be conducted on at least a weekly basis in long-term care. The physician's order dated 1/10/26 directed to apply Triad to the left buttock open area every shift. Review of the clinical record failed to identify a nurse's note or assessment dated [DATE] that addressed the resident's newly identified skin impairment to the buttock. The care plan dated 1/10/26 identified Resident #20 had a left buttock stage 2 pressure injury with interventions provide incontinent care every two hours and as needed and to reposition every two hours. The Wound nurse note dated 1/13/26 identified Resident #20's buttocks area with MASD with treatment to cleanse with soap and water, apply triad paste twice daily and prn with incontinent care. Add nutritional supplements and specific turning/repositioning program. 1.5 cm in length by 0.7 cm in width with a depth of 0.1 cm. The Wound MD documentation dated 1/15/26 identified Resident #20 was evaluated for new stage 2 pressure ulcer to the left buttock and indicated there was no peri wound erythema, induration, or fluctuance and no drainage noted from the wound bed on exam today. Wound MD note directed to begin triad for management and identified if wound appears to be worsening, will recommend back to bed schedule as resident would benefit from being on air mattress more frequently and from not sitting for hours in the wheelchair. Observation of Resident #20 on 3/13/26 at 9:04 AM in the dining room/lounge. Observation on 3/13/26 at 11:14 AM identified Resident #20 was in the dining room/lounge seated in the custom wheelchair leaning on the left hip with a travel pillow under the left side of the neck. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #20 indicated that Resident #20 had not changed position since previous observation. Review of the clinical record failed to identify documentation of the implementation of turning and repositioning. Interview with NA#4 on 3/13/26 at 11:50 AM identified she was caring for Resident #20 and brought the resident into the resident lounge in the morning after care was provided in the resident room. NA#4 indicated she did not know the time Resident #20 was placed in the lounge but identified that Resident #20 had been sleeping in the lounge with no care provided. Interview with RN#2 (Wound RN) on 3/16/26 at 9:46 AM identified when Resident #20's skin was noted to have blanchable redness on 12/9/25, the area should have been assessed to determine the cause, whether moisture or pressure. RN#2 indicated that on admission each resident should have some sort of barrier cream use in place and turning and repositioning every 2 hours if the resident is not able to do it themselves. RN#2 identified that she took over the wound RN position in December 2025 and had not been made aware of Resident #20's reddened area until notified of a wound 1/13/26. Interview with MD#1 (Wound MD) on 3/16/26 at 12:07 PM identified that Resident #20 had a lot of co-morbidities including bedbound, dementia, cachectic and should have been monitored more closely. MD#1 indicated that wounds are referred to the wound MD when they are non-blanchable. MD#1 identified that a blanchable area warranted interventions of aggressively offloading, ordering an air mattress but indicated that when he first saw Resident #20 the area was a stage II pressure with an open area. MD#1 identified that it would be highly unlikely that the turning and repositioning and care was being completed appropriately and that if the area had been monitored appropriately, Resident #20 should have been referred when the area was non-blanchable, which would have been the next progression after blanchable. Interview with the DNS on 3/16/26 at 1:59 PM identified skin checks should be completed weekly with baths and indicated that when a document is opened it should be completed and signed on the date of service. The DNS identified that the new skin findings documented on 12/9/25 and 12/23/25 should have been followed up with a nursing assessment. The DNS indicated that she did not find a nursing assessment to correspond with the notes. Interview with LPN#5 on 3/16/26 at 3:07PM identified when an issue with a resident's skin is found, the supervisor should be notified to do an assessment. LPN#5 reviewed Resident #20's clinical chart and indicated that documentation on 12/9/25 was correct and LPN#5 identified she had notified RN #4 who was the nursing supervisor on that date. LPN#5 reviewed the documentation dated 12/23/25 and indicated that this documentation was from 1/6/26 and could not identify if there was skin documentation made on 12/23/25. Interview with RN#4, nursing supervisor on 3/16/26 at 3:43 PM identified that although she could not remember the particular day, indicated that had she been told about Resident #20's skin, she would have addressed the resident and put a note in the clinical chart based on the assessment. RN#4 identified that she had no recollection of being told about redness to Resident #20's skin. Facility policy for wound treatment management identified wound treatments would be provided in accordance with physician's orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy for skin assessment identified a full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The policy identified this as part of the systematic approach to pressure injury prevention. The policy indicated the assessment would include the general status of the resident's skin to include color, temperature, moisture status, sensory perception, skin texture, turgor and perfusion and should be documented along with description of the wound to include measurements, color, type of tissue in wound bed, drainage, odor, pain.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, review of facility documentation, review of facility policy and interviews, the facility failed to ensure expired medications were removed from active use. The findings include: Observation of the North 1 medication cart on 3/16/26 at 10:21 AM with LPN #8 identified Meclizine tab 12.5 mg with an expiration date of 12/31/25 with 29 tablets remaining in the bubble pack.Interview with LPN #8 on 3/16/26 at 10:25 AM identified that expired or discontinued medications should be removed from the medication carts. LPN#8 indicated that all nurses are responsible for ensuring the medication cart does not have expired or discontinued medications. Observation of the North 2 medication cart with LPN #10 identified the following expired medications: two blister packs of Ondansetron tab 4 mg with an expiration date of 1/12/26 and Meclizine 12.5 mg (24 tablets) with expiration date 12/30/25 Observation of the North unit medication room with LPN#10 on 3/16/26 at 11:03 AM identified a box of Duoneb (Ipratropium Bromide and Albuterol) solution that contained 3 sealed multi packs and 3 single use vials with an expiration date of January 2026 on a shelf containing active use overflow medications. Interview with LPN#10 on 3/16/26 at 11:05 AM identified that expired or discontinued medications should be removed from active use, the medication cart or active use medication area in the medication storage room and placed in a bag to be sent to pharmacy or destroyed. Interview with the ADNS on 3/16/26 at 11:40 AM identified that expired medications should be removed from the medication carts to be returned to pharmacy. The ADNS indicated that all nurses are responsible for the medication carts and that the night shift nurses usually go through the medication carts. The facility policy for medication storage identified medications must be stored in accordance with manufacturer's specifications and in compliance with state and federal requirements and accepted professional standards of practice. The policy further identified prior to and after opening, all medications shall expire on the date specified by the manufacturer on the product label, unless the manufacturer has specifically indicated a shortened expiration once opened on the product label itself.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #27) reviewed for dental, the facility failed to ensure dental services were provided. The findings include: Resident #27 was admitted to the facility in July of 2022 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left side, hypertension, gastro-esophageal reflux disease without esophagitis. The quarterly MDS assessment dated [DATE] identified Resident #27 had intact cognition. The care plan dated 1/26/24 identified Resident #27 had an oral/dental problem related to complaints due to a history of peri-oral skin lesions with interventions to be free of infection, pain or bleeding, to receive a dental consultation annually/as needed, and to monitor for signs or symptoms of dental problems needing attention. Review of care conference notes dated 4/7/25 identified Person #3 reiterated Resident #27 has limited funds and is not interested in pursuing dentures as Person #3 felt most likely the resident will not be able to manage them. Interview on 3/9/26 at 10:30AM with Resident #27 identified she/he was edentulous since admission and wanted dentures but noted Person #3 (family member who handles resident's finances) would not pay for the dentures. Resident #27 identified that she/he had not received dental services for the duration of her/his time in the facility and no one had reached out to a dentist or dental service to identify if there would be an out of the pocket cost for services. Resident #27 has further stated the process was in the works prior to coming into the facility for her/him to get dentures however Person #3 canceled the order once admitted into the facility. Review of the clinical record identified Resident #27 had not been seen by dental for the past two years. Review of the clinical record failed to identify that the resident had elected to be provided with dental services through the facility's contracted dental provider. APRN#2's progress note dated 1/30/25 identified Resident #27 reported a desire to be seen by the dentist and evaluated for dentures. The resident reported that Person #3 canceled a denture order. APRN#2 requested nursing staff to place the resident in the Health Drive book for evaluation. (Not seen by health drive, no evaluation found.)Interview with MDS Coordinator #1 on 3/11/26 at 1:40PM identified Health Drive services are available for the residents if they don't have an outside dentist that they see. An oral exam is done on admission by the nurse and quarterly. Interview with the Administrator on 3/11/26 at 2:15PM identified Health Drive is available for residents who don't have an outside dentist and if they want an outside dentist they can help them obtain one. The Administrator further identified Resident #27 had been requesting dentures for a while, but Person #3 had stated they would not pay for them, so it had not been pursued. The Administrator further could not identify if Person #3 was the power of attorney or conservator for Resident #27 and able to make those decisions. Interview with the Administrator on 3/12/26 at 8:40AM identified that when Resident #27 was admitted , Person #3 was deemed the decision maker for Resident #27 due to the cognitive status at that time. Person #3 was responsible for finances for Resident #27 and listed as the emergency contact. The Administrator identified that she spoke with Resident #27 a few weeks back and she had spoken again about wanting dentures and she let the social worker know. Interview with the Social Worker #1 on 3/12/26 at 10:30AM identified Resident #27 had been talking for several months about getting/wanting dentures and had been involved with the Administrator. Resident #27 has always said she/he wanted dentures, but Person #3 would not buy them. Social Worker #1 identified she had not reached out to Health Drive to find out if there would be any associated cost for Resident #27 to be seen or for dentures nor has Social Worker #1 reached out to Person #3 regarding dental. Interview with Social Worker #2 on 3/13/26 at 10:05AM identified Resident #27 wanted to follow up with Person #3 and then about a week ago the Administrator spoke with Resident #27 and Social Worker #2 went down to bring the paperwork to sign up and spoke to the admission director to have Resident #27 be seen. Social Worker #2 identified she had multiple discussions with the resident that are not documented about his/her desire to get (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dentures. Social Worker #2 identified she had not spoken to Person#3 to clarify any information regarding the services offered. Interview on 3/13/26 at 10:30AM with Scheduler #1 identified she was not aware of Resident #27 signing up for services and did not have any documentation regarding it. Nor had Resident #27 been included in the upcoming schedule yet dated 3/16/26. Review of the quarterly audit report from Health Drive provided by the administrator identified Resident #27 was on dental services on the report dated 8/29/25. However, then dropped off the report. Interview with Health Drive #1 on 3/13/26 at 12:29PM identified Resident #27 was enrolled the previous day 3/12/26 for dental services. Resident #27 was enrolled on 4/2/25 for dental, however on 4/3/25 the service was cancelled. Prior to that there was no enrollment in dental services. Following the 4/2/25 enrollment and the 4/3/25 cancellation Resident #27 was put in a Do not treat status. This was why the resident came up enrolled in dental on the quarterly audit report. Health Drive #1 further identified there is not typically an out-of-pocket cost for dentures for a resident on Medicare and Medicaid insurance if they have not received dentures before. Interview on 3/16/26 at 8:42 AM with Person#3 identified the dentures have been a discussion ever since Resident #27 was at the facility, however Person #3 identified if Medicare won't pay for the dentures, then Medicaid won't pay for the dentures. Person #3 further identified that he/she is not paying for dentures. Person #3 identified the facility had never reached out to Health Drive to find out if there would be an estimated cost for Resident #27. Interview on 3/16/26 at 10:47AM with APRN#2 identified she knew about Resident #27 wanting dentures and has been trying to get them for a while however each time APRN#2 brings it up with Resident #27, the resident responds that Person #3 isn't going to pay for it. APRN#2 identified that the resident is not seen by the APRN for routine visits only the acute issues. APRN #2 identified that at a minimum she would expect Resident #27 to be seen at least annually by the dentist. APRN#2 further identified that although she was aware of the denture issue she assumed that Resident #27 was being seen by dental and was unaware that there were no services provided by the dentist to the resident. APRN#2 identified that there is an order set typically put in on admission for dental by the MD. Review of the Dental Services Policy identified the dental needs of each resident are identified through the physical assessment and MDS assessment processes and are addressed in each resident's plan of care. Residents and/or representatives are notified of dental services available under the State plan and of the potential charges that may apply in the case of routine or emergency dental care provided by outside resources.Although a policy was requested regarding next of kin/responsible party one was not received.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, facility policy and interviews, for one of three residents (Resident #94) reviewed during a review of the antibiotic stewardship program, the facility failed to ensure that an antibiotic time out was completed for a resident on an antibiotic and the facility failed to provide documentation of antibiotic usage, patterns and resistant trends. The findings include: Resident #94's diagnoses included Parkinson's disease, atrial fibrillation, and dementia. The quarterly MDS assessment dated [DATE] identified Resident #94 had severely impaired cognition and was dependent for personal hygiene. The physician's order with an origination order date of 8/15/25 directed Erythromycin Ophthalmic ointment 5 milligram/gram to instill one ribbon in both eyes at bedtime for eye infection and to continue until seen by ophthalmologists. Review and interview on 3/13/26 at 10:11 AM with the ADNS and RN #4 of Resident #94 clinical records failed to identify an antibiotic time out that was completed within 48 to 72 hours of the resident starting the antibiotic. RN #4 and the ADNS identified that the antibiotic time out is located in the evaluation section of the electronic medical records and is completed within 48 to 72 hours and should have been completed by the Infection Preventionist with feedback from the provider after the start of an antibiotic to identify if the antibiotic is working, to review the laboratory result to see if the antibiotic needs to continue or change. RN #4 and the ADNS identified it was the responsibility of the then IP nurse at the time to complete the antibiotic time out with the provider and document the feedback provided by the provider and are not sure if the resident has been seen by the eye provider. Review of the Antibiotic Stewardship Program policy identifies to monitor response to antibiotics, and laboratory results when available to determine if the antibiotic is still indicated or adjustment should be made. The policy further identified nursing will monitor the initiation of antibiotics on residents and conduct an antibiotic time out within 48-72 of antibiotic therapy to monitor with response on response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustment needs to be made based on the findings. A request was made on 3/11/26 for the quarterly infection control reports presented at medical staff meetings for the period of June 2024 through March 2026. The reports provided were dated 7/17/24, 10/16/24, 1/22/25, and 7/16/25. A review of the Antibiotic Stewardship program, monthly infection surveillance reports and quarterly infection control reports for the period of June 2024 through March 2026 with the ADNS and RN #4 on 3/13/26 at 10:11 AM failed to identify the number of antibiotic usages for the period of June 2025 through April of 2025 and for January to February 2026. The ADNS identified that she was not working as the IP nurse during that period, and it was the IP nurse's responsibility at the time to present the information at the quarterly medical staff meeting and maintain monthly tracking as seen in the other months that were completed. The ADNS identified just started to oversee the IP program in January of 2026 and was not familiar with the facility's IP program and is currently the facility's practice. RN #4 identified she had started recently to track the antibiotic usage in the facility but has not completed the reports. Review of the Antibiotic Stewardship Program policy identifies the Infection Preventionist utilizes expertise and data to inform strategies to improve antibiotics use to include tracking of antibiotics starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistance organism. The program includes antibiotic use protocols and a system to monitor antibiotic use. The policy further identifies at least annually or per facility policy feedback shall be provided on the facility's antibiotic use data in the form of a written report shared with administration, medical and nursing staff, and QAA committee. Based on review of clinical records, review of facility documentation, facility policy and interviews, for one of three residents (Resident #94) reviewed during a review of the antibiotic stewardship program, the facility failed to ensure that an antibiotic time out was completed for a (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident on an antibiotic and the facility failed to provide documentation of antibiotic usage, patterns and resistant trends. The findings include:

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** NMBased on review of clinical records, review of facility documentation, and interviews for one of three sampled residents (Resident #36) reviewed for pressure injury, the facility failed to ensure the comprehensive MDS assessment was accurately coded to reflect the resident was admitted with pressure injuries and for one of four sampled residents (Resident #61) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the MDS accurately reflected the resident's status. The findings include: 1. Resident #61's diagnoses included bipolar disorder, and schizophrenia. A positive PASRR level II assessment dated [DATE] was completed for Resident #61. The annual MDS assessment dated [DATE] identified Resident #61 was cognitively intact and did not display behaviors. The assessment further reflected that the resident did not have a positive level 2 PASRR. Interview with the MDS Coordinator (LPN#4) on 3/13/26 at 1:30PM identified that he was responsible for completing the section of the MDS that addressed PASRR level 2 status for Resident #61 on the most recent annual assessment. He noted that when making the determination of status, he checks the medical record and looks for the level 2 PASRR assessment. LPN#4 further identified that if he does not see a PASRR level 2 he would further verify with social work if the person had a positive PASRR level 2 assessment. He recalled checking the clinical record, however, did not recall verifying with social work. LPN#4 identified the annual MDS assessment for Resident #61 should have been coded positive for a level 2 PASRR. The MDS 3.0 Completion policy directed all disciplines to follow guidelines in Chapter 3 of the current RAI manual for coding each assessment. The Resident Assessment Instrument (RAI) manual provides guidance on how to complete the MDS assessment. And it notes that a positive PASRR screen indicates the resident has a mental illness, intellectual disability, or a related condition and should be coded in section A1500 as yes. 2. Resident #36's diagnoses include type 2 diabetes mellitus, anemia, and pneumonia. Resident #36 was readmitted to the facility on [DATE] and the weekly wound evaluation dated 2/19/26 at 7:00 PM identified the resident had a suspected deep tissue injury to the right heel, the left heel, stage 2 pressure injury to the right elbow, right outer ankle, and to the coccyx. The admission MDS assessment dated [DATE] identified Resident #36 was at risk for developing pressure ulcer/injuries but noted that the resident did not have any pressure ulcers present. Interview on 3/13/26 at 1:23 PM with MDS Coordinator (LPN #1) identified there are two MDS Coordinators and they are responsible for completing section M (skin condition) of the MDS assessment. LPN #1 identified that information is retrieved from the resident's admission assessment/evaluation, skin/wound document, and the wound provider notes to complete section M of the assessment. LPN #1 reviewed Resident #36's wound provider notes, the admission assessment/evaluation, the weekly wound evaluation and identified Resident #36 had a total of 4 pressure injuries when she completed the MDS assessment dated [DATE]. She noted that the (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	03/16/2026

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

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	assessment should have reflected the presence of the pressure ulcers/injuries. Interview on 3/13/26 at 2:09 PM with the other MDS Coordinator (LPN #4) in the presence of LPN #1 and the DNS identified that he was responsible for completing Resident #36's admission MDS assessment dated [DATE] and thought that he had captured the pressure injuries/ulcers on the assessment. LPN #1 and LPN #4 identified that when completing the MDS assessments, it is their responsibility to ensure that the assessment is completed accurately and not the responsibility of the ADNS because when she signs the MDS assessment it is only to indicate that the assessment was completed. Review of the MDS 3.0 Completion policy identified that according to federal regulations, the facility conducts initially and periodically a comprehensive and standardized assessment of each resident's functional capacity, using the RAI specified by the state. The policy further identified in the section Care Plan Team Responsibility for Assessment Completion that persons completing part of the assessment must attest to the accuracy of the section they complete by signature and indication of the relevant section.