STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Center for Rehabilitation and Healing L	395 Interstate Drive Manchester, TN 37355

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to perform an assessment for the use of a seatbelt for 2 residents (Resident #34 and #67) of 3 residents reviewed for physical restraints.The findings include: Review of the facility's policy dated 4/2017 titled Use of Restraints, revealed .individuals shall be reviewed regularly (at least quarterly) . Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Morbid Obesity, and Type II Diabetes. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #34 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact. Review of the comprehensive Care Plan initiated 4/26/2026 and revised 4/30/2026, revealed .Resident is at risk for falls r/t [related to] impaired mobility .use of proper assistive device . and .Resident requires PT/OT [physical therapy/occupational therapy] due to .impaired ROM [range of motion] .wheelchair management and mobility training . During an observation on 6/2/2026 at 3:00 PM, Resident #34 was in her power wheelchair with a lap belt secured around her waist. During an interview on 6/3/2026 at 1:37 PM, the Director of Rehab (DOR) stated Resident #34 was not assessed for the use of a lap belt. DOR stated Resident #34 does not utilize the lap belt on her power wheelchair. During an observation on 6/3/2026 at 3:30 PM, Resident #34 was in the common area seated in her power wheelchair with the lap belt secured around her waist. During an observation/interview on 6/3/2026 at 3:32 PM, the Director of Nursing (DON) confirmed Resident #34 had a lap belt secured around her waist and stated the resident had not been assessed for use of a lap belt. Medical record review revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Abnormal Posture, and Depression. Review of the MDS assessment dated [DATE] revealed Resident #67 scored a 13 on the BIMS indicating the resident was cognitively intact. Review of the comprehensive care plan dated 4/2/2026, revealed Resident #67 had .OT [occupational therapy] services related to .abnormal posturing of hemiplegic limb [paralysis on one side of the body] in current power chair .R [right] hand contracture [stiff and limits normal movements] . During an observation on 6/1/2026 at 3:53 PM, Resident #67 was observed sitting in her power wheelchair out in hallway with a lap belt secured across her right arm and waist. During an interview on 6/1/2026 at 5:00 PM, Certified Nurse Assistant (CNA) A stated Resident #67 had a belt on her power wheelchair to keep her from falling out, she thinks. CNA A further stated 2 residents on the hall had a power wheelchair with a lap belt. During an observation on 6/3/2026 at 12:25 PM, In Resident #67's room revealed Resident #67 was sitting in her power wheelchair with a lap belt secured around her right arm and waist. During an interview on 6/3/2026 at 1:37 PM, the DOR stated Resident #67 was not assessed by the therapy department for the use of a lap belt. During an interview on 6/3/2026 at 2:30 PM, the DON stated the lap belt was used for positioning the resident's right arm. The DON confirmed Resident #67 had not been assessed for the use of a lap belt since obtaining the wheelchair in 12/2024.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to implement the care plan for the use of a lap belt for 2 residents (Resident #34 and #67) and for falls for 1 resident (Resident #107) of 15 residents reviewed for care plans. The findings include: Review of the facility's policy dated 4/2017 titled Use of Restraints, revealed .care plans for residents in restraints . Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Morbid Obesity, and Type II Diabetes. Review of an admission MDS assessment dated [DATE], revealed Resident #34 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of the comprehensive Care Plan initiated 4/26/2026, revealed .Resident is at risk for falls r/t [related to] impaired mobility .use of proper assistive device . and .Resident requires PT/OT [physical therapy/occupational therapy] due to .impaired ROM [range of motion] .wheelchair management and mobility training . No care planning was found for lap belt restraint. During an observation on 6/3/2026 at 3:30 PM, Resident #34 was in the common area seated in her power wheelchair with the lap belt secured around her waist. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Abnormal Posture, and Depression. Review of the quarterly MDS assessment dated [DATE] revealed Resident #67 scored a 13 on the BIMS assessment indicating the resident was cognitively intact. Review of the comprehensive care plan dated 4/2/2026, revealed Resident #67 had .OT [occupational therapy] services related to .abnormal posturing of hemiplegic limb [paralysis on one side of the body] in current power chair .R [right] hand contracture [stiff and limits normal movements] . During an observation on 6/1/2026 at 3:53 PM, Resident #67 was observed sitting in her power wheelchair out in hallway with a lap belt secured across her right arm and waist. During an interview on 6/1/2026 at 5:00 PM, Certified Nurse Assistant (CNA) A stated Resident #67 had a belt on her power wheelchair to keep her from falling out, she thinks. CNA A further stated 2 residents on the hall had a lap belt in their power wheelchairs. During an observation on 6/3/2026 at 12:25 PM, In Resident #67's room revealed Resident #67 was sitting in her power wheelchair with a lap belt secured around her right arm and waist. During an interview on 6/3/2026 at 12:30 PM, the Director of Nursing (DON) stated the lap belt for Resident #67 was used for positioning the resident's right arm. The DON confirmed Resident #34 and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #67's care plans were not accurate and did not reflect the use of the lap belt. Review of the medical record revealed Resident #107 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Age-Related Physical Disability, and Repeated Falls (added on 3/13/2026). Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #107 scored a 1 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was severely cognitively impaired. Further review revealed the resident required partial/moderate assistance with transfers, and substantial/maximal assistance with toileting. Review of the comprehensive care plan dated 3/11/2026, revealed Resident #107 had an intervention for Dycem to wheelchair. During an observation/interview on 6/2/2026 at 3:03 PM, Licensed Practical Nurse (LPN) B assisted Resident #107 to stand up from her wheelchair and confirmed Resident #107 did not have Dycem in her wheelchair. During an interview on 6/3/2026 at 11:11 AM, the Director of Nursing confirmed Resident #107 did not have Dycem in her wheelchair.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, and interviews, the facility failed to revise the care plan for 1 resident (Resident #107) of 15 residents reviewed for care plans.The findings include:Review of the medical record revealed Resident #107 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Age-Related Physical Disability, and Repeated Falls (added on 3/13/2026).Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #107 scored a 1 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was severely cognitively impaired. Further review revealed the resident required partial/moderate assistance with transfers, and substantial/maximal assistance with toileting.Review of the comprehensive care plan revised 6/2/2026, revealed Resident #107's care plan did not reflect bed in lowest position, floor mat to right side of bed, or nightlight. During an observation on 6/1/2026 at 11:54 AM, in Resident #107's room revealed the bed in lowest position, a floor mat on the right side of her bed, and a nightlight plugged in at the foot of her bed. During an observation on 6/2/2026 at 10:14 AM, in Resident #107's room revealed the bed in lowest position, a floor mat on the right side of her bed, and a nightlight plugged in at the foot of her bed. During an interview on 6/3/2026 at 11:11 AM, both the Director of Nursing and the Administrator confirmed Resident #107's care plan had not been revised to reflect bed in lowest position, floor mat to right side of bed, or nightlight.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations and interviews, the facility failed to ensure proper infection control practices during medication administration for 1 resident (Resident #18) of 5 residents reviewed for medication administration.The findings include: Review of the facility policy titled, Administering Medications, dated 4/2019, revealed .Staff follows established facility infection control procedures .for the administration of medications . Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Failure, Diabetes Mellitus, and Chronic Pain Syndrome. Review of the current physician's recapitulation orders for Resident #18 revealed, .Eliquis [medication to thin blood] 5 mg [milligram] .twice a day .Benzonate [medication for cough] 200 mg .every 8 hours .Duloxetine [medication for depression] 40mg .one time a day .Farxiga [medication for diabetes] 10 mg .one time a day .Furosemide [medication to reduce fluid in the body] 40 mg .twice a day .Gabapentin [medication for nerve pain] 400 mg .twice a day .Hydrocodone-Acetaminophen [medication for pain] 10/325 mg .every 8 hours .Metoprolol [medication for high blood pressure] 100mg .one time a day .Oxybutin [medication for urinary spasm] 5 mg .one time a day .Potassium 5mg .twice a day .Sertraline [medication for depression] 75 mg .one time a day . During observation of a medication administration on 6/2/2026 at 7:43 AM, Licensed Practical Nurse (LPN) B prepared medications for Resident #18 and removed the Eliquis 5 mg, Benzonate 200mg, Duloxetine 40mg, Farxiga10 mg, Furosemide 40 mg, Gabapentin 400 mg, Hydrocodone-Acetaminophen 10/325 mg, Metoprolol 100mg, Oxybutin 5 mg, Potassium 5mg, Sertraline 75 mg by placing the medications into her hand and then into the medication cup. Continued observation revealed LPN B administered the medications to Resident #18. During an interview on 6/2/2026 at 7:53 AM, LPN B stated she was able to touch the pills because they (medication/pills) were not hazardous medications/pills. During an interview on 6/2/2026 at 2:15 PM, the Director of Nursing (DON) confirmed it was her expectation for staff to follow infection control practices which includes not touching medications with hands.