VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 14, 2023

Ms. Cathy Williams, Administrator
Mansfield Place
18 Carmichael Street
Essex Junction, VT 05452-3170

Dear Ms. Williams:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 23, 2023**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licens1na and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1011	A. BUILDING: _____ _ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANSFIELD PLACE	18 CARMICHAEL STREET ESSEX JUNCTION, VT 05452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 5/23/23 by the Division of Licensing and Protection. The following regulatory violations were identified:	R100		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record review and facility video the ALR (Assisted Living Residence) failed to ensure a resident with a disability consistently received the necessary care and services for 1 applicable resident. (Resident #1) Findings include: Per record review, Resident #1 is dependent on staff for transfers, dressing and toileting requiring 1 person assistance. Although Resident #1 has a diagnosis of a progressive neurological disease, s/he continues to maintain independence, despite mobility limitations and disability. After breakfast on 5/11/23 at approximately 10:00 AM Resident #1 used his/her call pendant requesting assistance with toileting. Per facility video, RA #1 (Resident Assistant) was observed entering the resident's room at 10:07 AM. The daily routine for toilet assistant involves Resident #1 transferring	R126	Tag R126 accepted 6/14/2023 - C. Scott/M. McIntosh	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Maureen Ellis, RAJ | Director of Operations | 6/13/2023, 5:08: 14 AM

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R126	Continued From page 1	R126		

from his/her motorized chair to a bedside commode. On 5/11/23 the transfer process included RA #1 having the resident stand by using a grab bar and pivoting to sit on the commode. Routinely, the resident is given the call pendant to alert staff when s/he requires assistance to return to his/her mobile device. However, before leaving the resident's apartment, RA #1 failed to hand the call device to Resident #1. For greater than 4.25 hours Resident #1 remained sitting on the commode, unable to stand or reach his/her call pendant which had been left on the resident's motorized chair at an unreachable distance. Resident #1's repeated calls for help went unnoticed. Per facility video, it was not until 2:25 PM when the Life Enrichment Director, who was passing by in the hallway, heard Resident #1's pleas for help. The Director called for immediate assistance and Resident #1 was removed from the commode and transferred back to her/his mobility chair. A large imprint was observed on the resident's buttock resulting from the prolonged seating position. Per interview at 10:25 AM on 5/23/23 the Life Enrichment Director described Resident #1 to be "in distress" and very "frustrated" when found.

Per interview on 5/23/23, Resident #1 stated the event "...was pretty bad...and should not have happened...." S/he recalled while sitting on the commode s/he was initially hopeful staff would notice s/he had not made it downstairs for lunch, anticipating someone would notice the resident's absence and would come to his/her apartment to remind the resident lunch was being served at 12:30 PM. However, staff did not seek out Resident #1. Per interview on 5/23/23 at 1:55 PM, the Health Services Director also confirmed a falsification of the Dinning Attendance Sheet which is completed for each meal by RA's.

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R126	Continued From page 2 Someone had marked on the Attendance Sheet Resident #1 was present for lunch in the main dining room, which was inaccurate. Resident #1 stated s/he became more anxious and frightened knowing lunch was served and still no one came to check on her/him. Resident #1 further stated most staff wait in the resident's apartment until s/he has completed toileting. "S/he just took off....and never came back....I was praying someone would help me.....banging on the wall and yelling for help.." Further interview on the afternoon of 5/23/23, the surveyor was informed RA #1 never reported to the other RA's, Resident #1 would require assistance and had been placed on the commode. RA #1 completed his/her shift and left the facility at approximately 1:30 PM while Resident #1 remained on the commode calling for help. Per interview with RA #2 at 12:50 PM confirmed Resident #2 requires significant staff assistance with transfers, experiencing some difficulty when standing. The RA also acknowledged, although staff are assigned to certain "groups" of residents for daily care "...everybody is responsible for all residents..." noting if a resident calls for assistance, whomever is available must respond. RA #2 denied receiving a report from RA #1 regarding the resident being placed on the commode nor had s/he heard Resident #1 yelling for help. Per interview with RA #3 at 11:58 AM on 5/23/23 reconfirmed RA # 1's "group" assignment included Resident #1, further stating there was no communication regarding Resident #1 requiring assistance. After an internal investigation of the 5/11/23 incident it was confirmed by the Health Service Director on 5/23/23 at 1:55 PM, RA #1 was terminated. An additional pendant was provided	R126		

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R126	Continued From page 3 to Resident #1 and placed on the grab bar beside commode along with additional staff training and review of responsibilities when providing care to all residents.	R126	Tag R213 accepted 6/14/2023 - C. Scott/M. McIntosh	
R213 SS=G	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, facility video, and record review, there was a failure by staff to ensure a resident was treated and provided care with consideration of their dignity, individuality and privacy. (Resident #1) Findings include: Per record review, Resident #1 is dependent on staff for transfers, dressing and toileting requiring 1 person assistance. Although Resident #1 has a diagnosis of a progressive neurological disease, s/he continues to maintain independence, despite mobility limitations and disability. After breakfast on 5/11/23 at approximately 10:00 AM Resident #1 used his/her call pendant requesting assistance with toileting. Per facility video, RA #1(Resident Assistant) was observed entering the resident's room at 10:07 AM. The daily routine for toilet assistant involves Resident #1 transferring from his/her motorized chair to a bedside commode. On 5/11/23 the transfer process included RA #1 having the resident stand by	R213		

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R213	Continued From page 4	R213		

using a grab bar and pivoting to sit on the commode. Routinely, the resident is given the call pendant to alert staff when s/he requires assistance to return to his/her mobile device. However, before leaving the resident's apartment, RA #1 failed to hand the call device to Resident #1. For greater than 4.25 hours Resident #1 remained sitting on the commode, unable to stand or reach his/her call pendant which had been left on the resident's motorized chair at an unreachable distance. Resident #1's repeated calls for help went unnoticed. Per facility video, it was not until 2:25 PM when the Life Enrichment Director, who was passing by in the hallway, heard Resident #1's pleas for help. The Director called for immediate assistance and Resident #1 was removed from the commode and transferred back to her/his mobility chair. A large imprint was observed on the resident's buttock resulting from the prolonged seating position. Per interview at 10:25 AM on 5/23/23 the Life Enrichment Director described Resident #1 to be "..in distress" and very "..frustrated" when found.

Per interview on 5/23/23, Resident #1 stated the event "...was pretty bad...and should not have happened...." S/he recalled while sitting on the commode s/he was initially hopeful staff would notice s/he had not made it downstairs for lunch, anticipating someone would notice the resident's absence and would come to his/her apartment to remind the resident lunch was being served at 12:30 PM. However, staff did not seek out Resident #1. Per interview on 5/23/23 at 1:55 PM, the Health Services Director also confirmed a falsification of the Dinning Attendance Sheet which is completed for each meal by RA's. Someone had marked on the Attendance Sheet Resident #1 was present for lunch in the main dining room, which was inaccurate. Resident #1

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R213	Continued From page 5 stated s/he became more anxious and frightened knowing lunch was served and still no one came to check on her/him. Resident #1 further stated most staff wait in the resident's apartment until s/he has completed toileting. "S/he just took off....and never came back....I was praying someone would help me.....banging on the wall and yelling for help.." Further interview on the afternoon of 5/23/23, the surveyor was informed RA #1 never reported to the other RA's, noting Resident #1 would require assistance and had been placed on the commode. RA #1 completed his/her shift and left the facility at approximately 1:30 PM while Resident #1 remained on the commode calling for help, experiencing total lack of consideration for his/her needs leaving the resident in an undignified and physically compromised situation. After an internal investigation of the 5/11/23 incident it was confirmed by the Health Service Director on 5/23/23 at 1:55 PM, RA #1 was terminated. An additional pendant was provided to Resident #1 and placed on the grab bar beside commode along with additional staff training and review of responsibilities when providing care to all residents.	R213		

Mansfield Place Assisted Living and Memory Care
18 Carmichael Street
Essex Junction, Vermont

Plan of Correction for complaint investigation completed: 5/23/23

Deficiency Regulation	Action/How the deficiency was corrected	Date corrected	System/facility changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R126 V. Resident Care and Home Services 5.5 General Care.	5/11/23- The clinical team evaluated and interviewed Resident #1. Resident's concerns/feelings were validated. Mansfield Place staff apologized for RA #1's omission of care, and any distress it may have caused. 5/31/23 Comprehensive response to support staff in honing EQ skills and utilizing evidence-based approaches—The Clinical Management team organized Broad education for nurses.	6/8/23	Issue was addressed promptly and appropriately on 5/11/23. In addition—a Trauma Informed Care (TIC) presentation by Lisa Lind, PhD, ABPP Board Certified Geropsychologist Chief Clinical Leadership Team Deer Oaks Behavioral Health was mandated for all licensed nurses. Education re: care delivery approach to understand, recognize and respond to the impact, and signs and symptoms of distress (completed by all nurses on 6/8/23).	Ongoing-All care and safety concerns will continue to be brought to the attention of the appropriate members of the Management team. Management will address all resident complaints/ significant incidents in a timely manner. Health Services Director (HSD) will monitor for utilization of learned TIC techniques for responding to residents/ situations moving forward.
R126 V.	5/11/23-RA #	5/11/23	Mansfield Place will	Ongoing-The

	1 was suspended pending an internal investigation.		continue with current measures. HSD followed standard investigation protocol.	HSD will continue to initiate swift and thorough investigation of all incidences of suspected abuse/neglect and take appropriate action.
R126 V.	5/12/23-The Clinical Management team identified a solution and provided an additional pendant to Resident #1. This was affixed to grab bar near Resident #1's commode to ensure ability to call for assistance.	5/12/23	The Clinical Management team made a concerted effort to employ a resident centered approach to address needs and mitigate identified safety concerns promptly and appropriately. Resident made aware of new grab bar pendant for toileting. Individualized Service Plan (ISP) updated so that care staff aware of needs/interventions moving forward.	Moving forward, the care staff are responsible for adhering to ISP and observing for Resident #1's "bathroom" pendant accessibility prior to leaving apt when toileting them. HSD to monitor process and address any episodes of non-compliance.
R126 V.	5/12/23-The Clinical Management team revised meal attendance procedure with goal of all residents being accurately accounted for at each	5/12/23	The Clinical Management team amended the daily meal tracking sheet to include staff using their initials for accountability. (Expectations posted on the meal tracker documentation clipboard)	Moving forward, the HSD collects and routinely reviews daily meal tracking sheets for correctness/ compliance

	mealtime.			
R126 V.	5/12/23- Incident reported to all appropriate parties per protocol.	5/12/23	MP will continue with current measures. The HSD collaborated with APS/DAIL/BON to ensure appropriate notifications occurred in a timely manner.	Ongoing-The HSD will continue to follow mandated reporter protocols.
R126 V.	5/12/23- The Clinical Management team identified and organized additional trainings for health services staff in order to reinforce essential standards of care including: abuse, pendant response, and reporting expectations. This abuse education is above and beyond standard annual training sessions. Abuse/Reporting information remains posted in the community, and is part of	6/12/23	Education by the Clinical Management team initiated by HSD/RN: • 5/12/23-Abuse/neglect/reporting • 5/12/23-Pendants and response expectations • 6/04/23-RA reporting expectations reviewed to ensure that all pertinent care and resident status information is reported off to another member of the team prior to staff member leaving community. Trainings conducted to ensure all staff remain in compliance with optimal provision of care moving forward.	Moving forward-The HSD has integrated this education into the new hire process and will continue to ensure that RAs are educated on: Pendant response, and reporting expectations as part of the orientation process. Ongoing- The HSD will continue to provide as needed refresher education to promote compliance. HSD will continue to ensure that care staff completes Abuse/Reporting training as part of their

	employee handbook guidance/yearly training curriculum.			mandatory annual inservice curriculum. Compliance monitored yearly on staff's hire anniversary.
R126 V.	5/15/23-The Management team made the determination to terminate employment of RA #1 after full investigation.	5/15/23	MP will continue with current measures. As part of standard investigation and follow through processes, Mansfield Place asserts that we will not retain an employee who we have determined exhibited clear disregard for the reasonable safety/wellbeing of a resident.	Ongoing-The HSD will continue to ensure resident safety and wellbeing via leading investigations of incidents and follow up which may include disciplinary action up to termination.
R213 VI. Residents' Rights	5/13/23-The clinical management team organized Broad Inservicing for care staff above and beyond standard annual training sessions. Resident Rights remain posted in the community and are part of employee handbook	6/12/23	The HSD initiated a Resident Rights Inservice to ensure the health services team remains in compliance with recognition and adherence to the fundamentals of Resident Rights moving forward.	Moving forward, the HSD will continue to provide as needed refresher education re: Resident Rights to keep staff cognizant of core principles. Ongoing-HSD will continue to ensure that care staff completes Resident Rights training as

	guidance/yearly training curriculum.			part of their mandatory annual inservice curriculum. Compliance monitored yearly on staff’s hire anniversary.