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

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 13, 2015

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 **June 23, 2015.** 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
Licensing Chief

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 _____	06/23/2015

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

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R100	Initial Comments: An unannounced, on-site re-licensure survey was completed on 6/23/15 by staff from the Vermont Division of Licensing and Protection. The following regulatory violations were found.	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident's medication, treatment and dietary services were consistent with physician orders for 2 of 7 applicable residents in the sample. (Resident #2 and #5). Findings include: 1. Per record review on 6/23/15, Resident #5 was admitted to the home on 11/3/14 and there were no signed physician admission orders in the medical record, and none were located anywhere else in the facility per interview with the Corporate Compliance RN at 3:05 PM the same day. There were 6 medications that the resident had been receiving daily since admission with no corresponding orders. There was a signed copy of Standing Orders dated 10/22/14, just prior to admission to the home. One other medication had a physician order dated 6/4/15. 2. Per record review on 6/23/15, Resident #2 was admitted to the facility on 8/29/14 and there were	R128	pls see page 1 of attachment poc accepted w attachments 8/12/15 Meg Baltzley	

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R128	Continued From page 1 no signed physician orders for the medications used by the resident. Per review of the record, 9 medications on the June 2015 MAR have no physician orders documented in the record. This was confirmed with the Compliance RN at 11:45 AM the same day.	R128		
R134 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that all resident assessments were complete, accurate and completed within 14 days of admission to the home for 3 of 7 residents in the applicable sample. (Residents # 1, #6 and #7). Findings include: Per review of the Resident Assessments for 7 residents during the survey, the following concerns were found with 3 resident reviews: a. late assessments - Resident #1, admitted to the home on 3/11/15, had a late Admission Assessment completed on 3/25/15. Additionally, the RN failed to date their signature upon	R134	pls see page 2 of attachment	

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R134	Continued From page 2 completion of the assessment. Resident #6, admitted to the home on 10/15/14, had a late Admission assessment completed on 10/31/15. b. incomplete assessments - Resident #1's assessment was incompletely documented for Section A and Section C. Resident #6's assessment was incompletely documented for Section J. Resident #7's assessment was incompletely documented for Section J. The failure to assure that assessments were completely documented within the required 14 days was confirmed with RN on 6/23/15 at 5 PM.	R134		
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to provide evidence of an assessment of a resident's ability to self-administer medication safely for 1 applicable resident in the sample. (Resident #4). Findings include: Per record review on 6/23/15, Resident #4 has physician orders to self-administer 2 daily medications used to treat chronic lung disease. Per interview on 6/23/15 at 2:30 PM, the facility RN confirmed that there had been no RN	R144	pls see page 3 of attachment	

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R144	Continued From page 3 assessment to determine if the resident was able to safely administer these medications.	R144		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that the care plans for 2 of 7 applicable residents addressed each resident's identified needs. (Resident #1 and #5). Findings include: 1. Per record review on 6/22/15, the care plan for Resident #1 was not revised to reflect the resident's improvement in bladder function. The care plan stated that the resident required daily assistance for toileting, and per interview with a caregiver at 5:22 PM, the resident has improved and is able to toilet independently. The care plan also failed to address the resident's chronic pain management needs. 2. Per record review on 6/23/15, Resident #5's care plan did not address the resident's needs regarding daily anticoagulant therapy, including monitoring for potential adverse effects of treatment and safety precautions.	R145	pls see page 4 of attachment	

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R145	Continued From page 4 These care plan issues were confirmed during interview with the RN on 6/23/15 at 5 PM.	R145		
R162 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that all resident medications administered by staff had a current physician's written order in the medical record for 5 of 7 applicable residents in the sample. (Resident #2, #3, #4, #6 and Resident #7). Findings include: 1. Per record review on 6/23/15, Resident #6 had no written physician orders in the medical record for 3 medications being administered daily - Folic Acid, Caltrate, and Plaquenil. The orders for Methotrexate (2.5 mg., 3 tabs PO Q week) from March, 2015 did not match the MAR (medication administration record) for June (2.5 mg. 5 tabs PO Q week), and there was no signed order in the medical record for the dose being administered in June. The resident also received Robitussin, originally ordered PRN and discontinued by the physician on 3/3/15, on 6 days during June, 2015. The order was never taken off the MAR or noted as "discontinued" on the MAR, so staff continued to administer it until the surveyor brought this to	R162	pls see page 5 of attachment	

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R162	Continued From page 5 staff's attention. The errors were confirmed with the RN on 6/23/15 at 5 PM. 2. Per record review on 6/23/15, Resident #7 had different physician orders for Sinemet doses and times, based on a review of the physician orders and the June, 2015 MAR. The physician (neurologist) orders dated 5/12/15 at 1349 hours stated: Sinemet (25/100), 13 tabs daily, 3.5 tabs at 10 AM, 3.5 tabs at 12 PM, 2.5 tabs at 5 PM and 3.5 tabs at 10 PM. The MAR stated Sinemet (25/100), 1 tab PO QHS, 3 (1/2 tabs, 37.5 mg./150 mg) PO TID. The discrepancy in the doses ordered was not noted by the RN and there was no evidence of a clarifying order in the medical record. The failure to note the order and MAR discrepancies and notify the physician for clarification was confirmed with the RN at 5 PM on 6/23/15. 3. Per record review on 6/23/15, Resident #4's MAR included Duo-Neb. 0.5 mg/3 ml., 3 ml/12.5 mg, 4 X QD and Lactobacillus (probiotic), 1 tab PO QD. There were no physician orders found for these 2 medications/supplements. This resident also had a different physician order for Lorazepam than was written on the June, 2015 MAR. The order, dated 5/1/15, stated Lorazepam, 1 - 2 tabs PO HS anxiety/sleep. The MAR stated Lorazepam, 0.5 mg. PO PRN sleeplessness. There was no documentation in the record to indicate the RN called to clarify what the orders should be, especially in regards to the dosing range given in the orders; if a dose range is used, there must be written parameters for staff to follow in deciding the appropriate dose to administer. These concerns were confirmed with the RN at 5 PM on 6/23/15. 4. Per record review, Resident #2 had different	R162		

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R162	Continued From page 6 physician orders for Lumnesta than was written on the MAR for June, 2015. The orders, dated 11/14/14, stated Lumnesta 2 mg. PO QHS insomnia. The MAR stated Lumnesta, 3 mg. PO HS insomnia. The discrepancy was confirmed with the Compliance RN at 6/23/15 at 11:45 AM. 5. Per record review, Resident #3's MAR did not include accurate orders, per review of the signed physician orders dated 5/7/15 and 5/25/15. The discrepancies include the following: APAP, order of 5/25/15 stated 500 mg. 2 tabs every 8 hours. The MAR stated 500 mg. , 2 tabs PO TID (3 times daily); Glimepiride orders of 5/7/15 stated 2 mg., take 1 -2 tabs at bedtime, the MAR stated 2 mg. PO HS; Novolog flex pen, orders of 5/25/15 stated 2 - 5 U., 2 - 5 U. at breakfast., the MAR stated 2 U. SC daily before breakfast. In addition, there were no signed orders for Albuterol Inh., Robitussin DM, and Milk of Magnesia. These concerns were confirmed with the RN at 5 PM on 6/23/15.	R162		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that	R167	pls see page 6 of attachment	

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R167	Continued From page 7 indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that there was a written plan for unlicensed staff to direct the administration of PRN (as needed) psychoactive medication for 2 applicable residents in the sample. (Resident #4 and #7). Findings include: 1. Per record review on 6/23/15, Resident #4 had current physician orders for Lorazepam (an anti-anxiety medication) to be given for anxiety or sleeplessness. The MAR indicated that the resident had been administered the Lorazepam 5 times during the month of June, as of 6/23/15. There was no PRN written care plan, as required by Vermont RCH Licensing Regulations, describing the specific behavior the medication was intended to treat, the circumstances when it may be given, educates staff about the desired effects and potential adverse side effects to monitor for, and documents the time of, reason for and specific results of the medication use. 2. Per record review, Resident #7 had physician orders for Lorazepam PRN anxiety/agitation dated 5/12/15. There was no PRN psychoactive care plan to direct unlicensed staff in the administration of this medication, per the regulatory reference stated above in example #1. The lack of the required PRN psychoactive care plans was confirmed during interview with the RN on 6/23/15 at 2:30 PM.	R167		

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R168 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that there was documented evidence of training for all unlicensed staff who administer insulin and have been deemed capable by the Registered Nurse (RN). During the survey, 2 staff were identified who administered insulin 2 times daily for 1 applicable resident of the home. (Resident #8). Findings include:	R168	pls see page 7 of attachment	

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R168	Continued From page 9 Per interview with the med-delegated RCA (resident care associate) on 6/22/15 at 4:40 PM, he/she currently administers insulin to Resident #8, who has physician orders for insulin injections twice daily, AM and PM. The RCA stated that he/she had been delegated to administer insulin and other medications by the previous facility RN. He/she also stated that they had received training on how to test a resident's blood sugar, using a glucometer. During interview on 6/22/15 at 5 PM, the current RN, who has been employed at the home for about 1 month, stated that she had observed the med-delegated staff for competency but confirmed that there was no documented evidence by the previous RN on insulin administration, including demonstration of competency, and diabetes training for the staff who currently administer this medication. Delegation does not transfer when a previous RN leaves his/her position, the new RN must delegate all staff under his/her license when there is a change in the RN in charge of delegation.	R168		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by	R171	pls see page 8 of attachment	

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R171	Continued From page 10 the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that there was a record of monitoring for adverse side effects for 1 applicable resident receiving psychoactive medication. (Resident #7). Findings include: Per record review on 6/23/15, Resident #7 receives daily medication therapy with an anti-psychotic medication. There was no evidence of monitoring for potential adverse side effects or abnormal involuntary movements for this classification of medication. The lack of required monitoring was confirmed during interview with the RN on 6/23/15 at 5 PM.	R171		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each	R179	pls see page 9 of attachment	

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R179	Continued From page 11 year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that all staff providing direct resident care completed the 7 Vermont RCH Regulation specified trainings during the previous 12 month period. One of five staff members in the total sample did not complete 5 of the 7 required trainings. Findings include: Per review of the staff training records for the last 12 months on 6/23/15 at 5 PM, 1 of the 5 staff in the sample did not complete 5 of the 7 Vermont required trainings at least annually. These findings were confirmed with the RN on 6/23/15 at 5:15 PM.	R179		
R220 SS=C	VI. RESIDENTS' RIGHTS	R220		

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R220	Continued From page 12 6.7 A resident may complain or voice a grievance without interference, coercion or reprisal. Each home shall establish a written grievance procedure for resolving residents' concerns or complaints that is explained to residents at the time of admission. The grievance procedure shall include at a minimum, time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the Office of the Long Term Care Ombudsman and Vermont Protection and Advocacy as an alternative or in addition to the home's grievance mechanism. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to meet the licensing regulations for the policy/procedure for filing of a resident grievance. Findings include: Per review of the facility's policy on resident grievances, the policy failed to include a process for responding to resident's in writing, as required by the Vermont Residential Care Home Licensing Regulations, effective 10/3/2000.	R220	pls see page 11 of attachment	
R230 SS=C	VI. RESIDENTS' RIGHTS 6.18 The enumeration of residents' rights shall not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall be written in clear language, large print, given to residents on	R230	pls see page 11	

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R230	Continued From page 13 admission, and posted conspicuously in a public place in the home. Such notice shall also summarize the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy, Inc. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post a copy of the Resident Rights in conspicuous public place in the home. Findings include: Per observations during the initial tour of the home on 6/22/15, a copy of the Residents Rights poster was not posted in a public place as required. The lack of the posting was confirmed with the Administrator after the tour.	R230		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to assure that all perishable foods were labeled and dated, in accordance with safe food handling practices, Vermont licensing regulations and facility policy. Findings include:	R247	pls see page 11 of attachment	

Division of Licensing 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 _____	06/23/2015

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

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R247	Continued From page 14 Per observations in the walk-in refrigerator on 6/22/15 at 9:45 AM, the following perishable foods were not labeled and dated: sliced turkey breast, sliced roast beef, and fillets of raw white fish. Additionally, per review on 6/23/15, the facility's "Storage of Products Policy" stated "Store left over prepared food in a container with an airtight lid...label the container with the type of food and the date...Left over foods which have not been frozen must be discarded after 3 days if not used." The observations were confirmed with the cook on 6/22/15 at 10 AM and the Director of Food Service on 6/23/15 at 1:15 PM.	R247		
R251 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all food and drinks were stored separate from possible sources of contamination in all areas of the kitchen where food was stored. Findings include: Based on observations in the kitchen food storage area on 6/23/15 at 10:40 AM, a mop station, for filling and disposing of floor washing water, was located immediately adjacent to the ice machine used for resident drinks and dietary needs. There were also foods and drinks stored	R251	pls see page 11 of attachment	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R251	Continued From page 15 across from the mop station. Per interview with the Director of Maintenance, who accompanied the surveyor on the tour, there was no other area in the kitchen where the ice machine could be placed, since it was directly plumbed into the wall water source. The lack of a wall (or some sort of impervious material) separating the 2 areas posed a potential contamination risk, with possible soiling of the outside of the ice machine (a clean area) and possible splashing of soiled water. The risk of contamination was confirmed with the Director of Maintenance at the time of the observation.	R251		
R259 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.i Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that cleaning products were appropriately and safely stored in a food storage area of the kitchen. Findings include: Per observation of the food storage area of the kitchen on 6/23/15 at 10:40 AM, cleaning compounds were observed stored on the shelving units with food products and drinks. During interview with the Director of Maintenance and the Food Service Director present for the tour, the	R259	pls see page 11 of attachment	

Division of Licensing 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 _____	06/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R259	Continued From page 16 surveyor confirmed that all poisonous compounds, including cleaning chemicals, must be stored in a separate locked compartment if they are located within a food storage area.	R259		
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure a safe and sanitary environment for 1 applicable observation during the survey. Findings include: Per observation of a staff member trained to conduct blood sugar testing on 6/22/15 at 4:40 PM, the staff member removed the used lancet (used to prick the skin to obtain a drop of blood) from the device and placed it in a paper tissue and transported it from the 3rd floor apartment to the first floor medication station, to dispose of in the impervious sharps container. When staff was asked how they usually dispose of a used lancet, they responded that they used to have sharps containers (for disposal) in the specific resident rooms where they would be needed. During interview immediately after the observation, the RN, who was new to the facility within the last month, stated that she had planned to assure that safe sharps disposal devices were in all resident rooms where they would be needed, based on the resident's needs. The RN confirmed that staff	R266	pls see page 10 of attachment	

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R266	Continued From page 17 should not be carrying a used lancet (without protection) through the facility for appropriate disposal.	R266		
R302 SS=B	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that records of all fire drills included the names of the participating staff for all drills in the last 12 months. Findings include: Per review (6/23/15) of the fire drill records for the past 12 months, staff failed to list the names of all staff present for each fire drill for the dates of 3/26/15, 5/29/15 and 9/30/14. The failure to include the names of staff present for the drills was confirmed with the Director of Maintenance on the morning of 6/23/15.	R302	pls see page 12 of attachment	

R 128 V. Resident Care and Home Services

5.5 General Care

5.5 (c)

Action:

- All identified findings will be corrected by 8/11/2015.
- All resident's medication, treatment and dietary services administered will be consistent with the physician's orders.

Measures:

- The nursing will conduct a three point check to ensure orders are in place, medications are in house and orders correctly transcribed into MAR will occur for all medications and treatment orders at the time of admission and for current residents.

Monitoring:

- Monthly audits of randomly selected Resident records performed by a licensed nurse (RN/LPN) to ensure comprehensive and accurate reconciliation of the orders in the MAR and TAR with signed physician orders.

Implementation:

- 10/1/2015

POC accepted as revised 8/12/15 MW

R134 V. Resident Care and Home Services

5.7 Assessment

5.7. (a)

Action:

- Within 14 days of admission Nursing will complete a comprehensive assessment per the instrument provided by the licensing agency for each resident and submit to the Facility RN for review and sign off.

Measure:

- A tickler system has been implemented to alert the Nursing team to an upcoming assessment submission date.

Monitoring:

- The professional nurse (RN/LPN) to conduct audits of the new resident admission paperwork to ensure each resident has a complete and signed assessment in place within 14 days of admission.

Implementation:

- 7/28/201.

GK accepted 8/12/15
Mary Baltazar

R144 V. Resident Care and Home Services

5.9 Level of Care and Nursing Services

5.9.c.(1)

Action:

- A Facility RN will review each current and new Resident's plan for medication administration.

Measure:

- A RN utilizing the "Medication Self-Administration Assessment Form" will assess the Resident's ability to safely self-administer one or more prescribed medications.

Monitoring:

- The HSD/RN Delegate will complete the Medication Self-Administration Assessment Form within 24 hours of admission to the facility.
- The Resident's ability to continue to safely self-administer medications will be evaluated annually and as the Resident's status indicates by the HSD/RN Delegate.

Implementation

- 10/01/2015

POC accepted 8/12/15
Mary Baltzell RN

R145 V. Resident Care and Home Services

5.9 Level of Care and Nursing Services

5.9. c (2)

Action:

- Within 14 days of admission to the facility a comprehensive and individualized care plan will be developed.
- Review and revision of all current care plans will occur.

Measures:

- The plan of care to be developed for each Resident based on the abilities and needs of the Resident as identified in the assessment process.
- The facility HSD or her Delegate will review, revise and sign off on all initial and revised plans of care.

Monitoring:

- The HSD/RN Delegate will review each resident care plan review at least annually and with change of status.
- Each care plan update will be reviewed and signed off by the facility HSD/RN Delegate.

Implementation:

- 10/31/2015

POC accepted 8/12/15
Mary Bates, RN

R162 V. Resident Care and Home services

5.10 Medication Management

5.10.c

Action:

- All identified findings will be corrected by 8/11/2015
- Facility Nurses will receive ongoing education and support in regards to appropriate strategies to note, reconcile and document physician orders in a manner that consistently supports the regulations of the licensing entity and safe medication practices.

Measures:

- A three point check for all medications and treatment orders will be completed by the Facility Nursing staff at the time of Resident admission. The three point check will include: orders in place, medications in house and orders correctly transcribed into MAR/TAR.
- Every month the Facility Nursing staff will reconcile all orders documented on the Resident MAR/TARs against Physician orders in the Medical Record.

Monitoring:

- Monthly audits of randomly selected Resident records performed by HSD/RN or LPN Delegate to ensure comprehensive and accurate reconciliation of the orders in the MAR and TAR with signed physician orders.

POC accepted 8/12/15
Meg Bartlett RN

Implementation:

- 10/01/2015

R167 V. Resident Care and Home services

5.10 Medication Management

5.10 (d)

Action:

- All identified findings will be corrected by 8/11/2015.
- A plan of care will be developed and include at a minimum each medication ordered, a description of the specific behavior the medication is intended to treat, the circumstances when it may be given, and information regarding desired and undesired effects that staff should monitor the resident for.

Measures

- A behavioral flow sheet and documentation defining medication, diagnosis, behaviors and appropriate intervention techniques will be in place for all "as needed" psychoactive medications ordered.
- The MAR will be used to document the administration time and effect of the medication when administered

Monitoring:

- The HSD/RN Delegate to be responsible for weekly audits of PRN psychoactive medication and communicate with prescribing professional as needed

Implementation:

- 10/01/2015

POC accepted 8/12/15
Mary Bates, RN

R168 V. Resident Care and Home services

5.10 Medication Management

5.10 (d) Insulin.

Actions:

- All staff who are delegated the responsibility of passing medications will be trained in the proper administration of subcutaneous Insulin.
- All delegated staff will receive Diabetes Education as part of the Medication Passer training.

Measure:

- All Delegated staff will demonstrate competency in the administration of insulin.
- Completion of the Relias training module addressing high risk medications annually.

Monitoring:

- The HSD/RN Delegate will assign and oversee annual competency and training.

Implementation:

- 10/30/2015

poc accepted 8/12/15 Mg Baltazar RN

R171 V. Resident Care and Home services

5.10 Medication Management

5.10 (g)

Action:

- All nursing staff and those Delegated with the task of Medication Passing will be educated/re-educated in the appropriate process for documenting scheduled and as needed medications as administered or refused.
- For Residents who receive psychoactive medications all Nursing staff and those Delegated with the task of Medication Passing will be educated about how to monitor, report and document side effects observed.

Measures:

- A current list of staff who delegated the task of Medication Passer is in place in each medication administration record (MAR) binder.
- All Nursing staff and those delegated the task of Medication Passer will complete annual training modules via the Relias Training program.

Monitoring:

- At least quarterly and more frequently as warranted the HSD/RN Delegate will monitor documentation of potential adverse side effects of all residents receiving psychotropic medications. Abnormal involuntary movements of all Residents receiving antipsychotic medications will be monitored per facility policy.
- At least annually and more frequently if warranted the HSD/RN Delegate will review and monitor training records to ensure all modules have been completed and appropriate competencies have been demonstrated.
- Implementation: 10/01/2015

PC accepted 8/12/15
Mary Baltz, RN

R179 V. Resident Care and Home services

5.11 Staff Services

5.11.(b)

Action:

- All current staff are in the process of completing annual training.
- Mandatory online training is made available to all staff hired into the role RA/Caregiver.

Measure:

- Annually the resident assistant (RA) must complete at a minimum 12 hours of training to include the following topics: resident rights, fire safety and emergency evacuation; resident emergency response procedures; policies and procedures regarding mandatory reports of abuse, neglect and exploitation; respectful and effective interaction with residents; infection control measures; and general supervision and care of the residents.

Monitoring;

- The HSD/RN or LPN Delegate to review program reports to ensure timely completion of training as assigned.

Implementation:

- 10/01/2015

POC accepted 8/12/15
Meg Baltzer RN

R266 IX. Physical Plant

9.1 Environment

9.1 A

Action:

- The facility will provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

Measure:

- All staff will complete annual training addressing education and training around - procedures for safe handling and disposal of sharps.

Monitoring:

- The HSD will provide annual review and maintain ongoing observation of best practices.

Implementation:

- 6/24/2015

POC accepted 8/12/15
Mary P. Baker, RN

R220 6.7 Resident's Rights

Mansfield Place has edited the verbiage in the grievance policy, making clear the process for responding to residents in writing. Grievance policy and process is provided to all residents prior to/upon admission.

Monitor: Executive Director/Designee

Completed 6/23/2015

POC accepted 8/12/15 Mry Baker, RN

R230 6.18 Resident's Rights

A copy of Resident's Rights hangs in the entryway of Mansfield Place. Quarterly visual inspection by the Director or designee will assure compliance.

Monitor: Executive Director/Designee

Completed 6/23/2015

POC accepted 8/12/15 Mry Baker, RN

R247 7.2b Food Safety and Sanitation

Mansfield Place will label and date all perishable food and drink.

Food Service Director or designee will provide staff education on safe food handling practices per regulations as well as conduct periodic inspections.

Monitor: Food Service Director/Designee

Completed 8/01/2015

POC accepted 8/12/15 Mry Baker, RN

R251 7.3 Food Storage and Equipment

A wall was constructed and installed between the mop station and ice machine to prevent cross contamination.

Storage rack with food items was relocated away from the mop station.

Monitor: Food Service Director/Designee

Completed 7/22/2015

POC accepted 8/12/15 Mry Baker, RN

R259 7.3 Food Storage and Equipment

Installed a locked cabinet for chemicals in kitchen

Monitor: Food Service Director/Designee

Completed 6/30/2015

POC accepted 8/12/15 Mry Baker, RN

R302 9.11 Disaster and Emergency Preparedness

Fire Drill Report now includes names of participating staff members.

Maintenance Director will quarterly review the Fire Drill Reports for compliance.

Monitor: Maintenance Director/Designee

Completed 7/17/2015

POC accepted 8/12/15 Meg Bolte, pw