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

March 18, 2024

Maureen Ellison, Manager
Mansfield Place
18 Carmichael Street
Essex Junction, VT 05452-3170

Dear Ms. Ellison:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 2, 2024.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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 _____	C 02/02/2024

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

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A 001	VI Initial Comments On 1/24/24 the Division of Licensing and Protection conducted an unannounced on-site investigation of one complaint. Additional information was provided by the facility on 1/25/24 - 1/27/24 and 2/1/24, and additional interviews were conducted on 1/25/24 and 2/1/24. The following regulatory deficiencies were identified during the investigation:	A 001	Mansfield Place takes these matters seriously, and has addressed these concerns as follows:	
A 607 SS=D	VI Resident Care and Services 6.7 Care Plans The licensee, the resident and/or the resident's legal representative shall work together to develop and maintain a written resident care plan for those residents who require or receive care. The care plan shall describe the assessed needs and choices of the resident and shall support the resident's dignity, privacy, choice, individuality, and independence. The licensee shall review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident's decision, behavior or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement. This Statute is not met as evidenced by: Based on observation, resident, staff, and provider interviews; and record review there was a failure to develop and maintain a written care plan which describes the resident's assessed needs and choices; and supports the resident's dignity and independence of one applicable resident (Resident #1). Findings include: Resident #1 has Multiple Sclerosis, right sided	A 607		

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A 607	Continued From page 1 weakness, and chronic restrictive lung disease. S/he uses an electric wheelchair for mobility and is dependent on staff for basic activities of daily living. Per record review, Resident #1's Care Plan dated 12/13/23 includes Toileting, Transfer/Mobility Status, and use of supportive devices to promote independence as areas of focus. Goals identified in the plan include "Will use the least restrictive device and risks will be minimized", "Will be able to toilet safely with assistance", and "Will be able to transfer safely"; however the Care Plan does not include goals and interventions related to activities and exercises recommended by his/her Physical Therapist to maintain abilities, improve strength and endurance, and potentially regain the use of a grab bar for sit to stand transfer from wheelchair to commode. The Care Plan states "12/19/23 Resident assessed by PT (Physical Therapist) Hoyer lift for all transfers" and states Resident #1 is "Unable to get in and out of bed, chair, car, etc without total physical assistance using Hoyer lift". Resident #1 had a fall while using a grab bar to stand as staff assisted with personal care on 11/24/23. On 12/7/23 s/he was diagnosed with pneumonia. Following these events Resident #1"s Primary Care Provider (PCP) ordered Home Health Physical Therapy (PT) to address significant loss of strength and endurance, and increased need for staff assistance with activities of daily living and transfers. A Physical Therapy assessment on 12/11/23 documents a reduction in the amount of time s/he was able to maintain a standing position at the grab bar from approximately one minute prior to the fall and illness to a 5 second standing tolerance. Resident #1 was hospitalized from 12/12/23 - 12/15/23 for continued respiratory symptoms, peripheral	A607:	Health Services Director/RN to oversee/ensure ongoing Service Plan updates and reviews annually and PRN-Tracked via audit of EMR PCC Clinical Dashboard and Summary Reports- to be evaluated at least bi-weekly. Mansfield Place has incorporated the principles of beneficence to Resident's Service Plan re: adapting to Resident's dynamic needs/progressive condition(s) - Staff will adjust personal care needs according to changing abilities to maintain comfort/dignity/and participation to the extent resident is able to be involved. Gauged via Resident response-Staff will solicit feedback during routine care and endorse Resident to share pertinent information/insights re: their care needs/services. -RN, LPN, RA, Med Passers to report findings to HSD - Interventions added to include Ongoing monitoring/evaluation and continued dialogue with resident and interdisciplinary team re: safety concerns, fluctuating ability level based on progression of/coexistent disease processes (e.g.: PAROXYSMAL ATRIAL FIBRILLATION; HEART FAILURE; PULMONARY HYPERTENSION; RESTRICTIVE LUNG DISEASE; OSTEOPOROSIS; and MULTIPLE SCLEROSIS), and capacity to perform tasks-such as standing at their bedside bar. Has h/o weakness/variable function (i.e. level of strength endurance demonstrated am vs. pm) In order to create realistic goals which can consistently be performed across all shifts safely for both resident and staff. - Service plan amended to include Independent exercises recommended by PT. (Per PT, no changes in transfer/mobility status should be addressesuntil a new PT eval can be performed) - 3/4/24-Conversation (HSD/Resident). Resident stated they feel safer using FBM lift and elect to continue use for transfers; Although has concerns that legs are weakening and would like to consider sanding exercises at bar - 3/4/24-To align with resident choice, PCP office contacted re: Office visit for re-evaluation for Home Health PT referral Appointment scheduled for 3/19/2024 - (Upon re-assessment, if needs are deemed unmanageable in ALF setting-HSD will arrange a Care Conference with key stakeholders, and NRA will be revisited and discussed with Resident to reach a mutually agreed upon solution--taking into account resident's preferences/dignity/independence. Service plan will be updated with status changes.)	ongoing 2/9/24 ongoing appraisal 2/9/24

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A 607	Continued From page 2 edema, and pulmonary hypertension. An Occupational Therapy (OT) assessment on 12/14/23 determined s/he was to be capable of transfers with one person assistance and another staff standing by for safety. Discharge to a subacute rehab facility (SAR) to restore strength, endurance, and improve independence with transfers and activities of daily living was recommended, however Resident #1 was not in agreement with discharge to SAR. The Assisted Living Residence required use of a Hoyer mechanical lift for all transfers for Resident #1 as a condition of return to the home. On re-admission Resident #1 was also required to remain in bed with staff providing frequent checks, range of motion exercises and repositioning every 2 hours while awaiting a Physical Therapy evaluation scheduled for 12/19/23. Assistance with toileting needs was limited to use of a bedpan and Depends during this waiting period, as the staff were unable to perform transfers during this time. Per review of the Home Health Physical Therapy Assessment dated 12/19/23, the Physical Therapist recommended staff assist Resident #1 with standing at the grab bar and an eventual goal of resuming use of the bar for toileting. Per the PT's instructions these interventions would benefit Resident #1's pulmonary function, bone and muscle strength, skin integrity and digestive function. The PT Assessment notes indicate the PT was informed by the Director of Health Services "this is not something staff can safely assist [Resident #1] with at any time moving forward". Physical Therapy evaluation notes describe Resident #1 as "very distraught regarding no longer having the opportunity to stand or transfer" and "distressed regarding this	A 607	A607: 12/19/23-Deer Oaks Services offered due to Emotional status r/t Non-compliance with rehabilitation program recommendations and functional status change -services were declined Staff will continue to reapproach based on emotional status	Ongoing

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A 607	Continued From page 3 expediating [his/her] loss of strength and mobility". Per the assessment notes, Resident #1 agreed to use the Hoyer lift for transfers from bed to wheelchair and recliner with a goal of regaining the ability to use the grab bar to stand for toileting. On the afternoon of 1/24/24 the Surveyor observed a Hoyer lift transfer of Resident #1 from wheelchair to bed to change his/her depends. Staff providing the Hoyer transfer stated a commode was not used for toileting due to difficulty removing and reapplying the Hoyer lift sling while seated on the commode. During an interview on the afternoon of 1/24/24 Resident #1 expressed s/he wanted to be allowed to stand at the grab bar to prevent further loss of ability to stand and use a commode, and to be allowed to independently transfer from wheelchair to recliner. During an interview commencing at 12:24 PM on 1/24/24 the Director of Health Services confirmed the use of a Hoyer lift was determined to be necessary by the facility to prevent resident and staff injuries during transfers, and confirmed the Physical Therapist expressed concern Resident #1 would lose function due to not being able to engage in weight bearing activities. It is the responsibility of the facility's Registered Nurse to ensure a resident's plan of care addresses current needs, goals, and interventions; however Resident #1's plan of care was not updated to include goals and interventions consistent with the recommendations of the physical therapist and to support the resident's needs and goals for maintaining independence. The facility's determination that Resident #1 required a Hoyer lift for all transfers was inconsistent with the OT's	A 607	A607: HSD continuing education 3/11/24 March 2024 E-Course Module: Service Plans for Assisted Living Facilities To better understand/implement Person-centered service plans help to direct individualized care for each resident in ALF. Through person-centered plans, staff can direct and provide quality, individualized care to the residents they serve. This course discusses the purpose and importance of person-centered service plans and how they are implemented. A607 Plan of Correction accepted by Jo A Evans on 3/15/24.	

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A 607	Continued From page 4 and PT's assessments indicating s/he was capable of sit to stand transfer using the grab bar with staff assistance. His/her care plan did not include goals and interventions which would allow the resident to practice pull to stand transfers and standing tolerance exercises using a grab bar with appropriate staff support to promote Resident #1's dignity, self-direction, participation in decision-making, and independence. This deficient practice is a potential risk for more than minimal harm due to care planning without development of goals and interventions consistent with the resident's assessed needs and supportive of resident dignity, choice, individuality, and independence.	A 607		
A 901 SS=D	IX Negotiated Risk 9.1 Whenever the licensee determines that a resident's decision, behavior or action places the resident or others at risk of harm, the licensee shall initiate a service negotiation process to address the identified risk and to reach a mutually agreed-upon plan of action. This Statute is not met as evidenced by: Based on resident, staff and provider interviews, and record review there was a failure to initiate a service negotiation process when one applicable resident (Resident #1) returned to the home after declining recommended discharge to a Sub Acute Rehab facility following hospitalization. Findings include: Per record review Resident #1 has Multiple Sclerosis, right sided weakness, and chronic restrictive lung disease. S/he uses an electric wheelchair for mobility and is dependent on staff	A 901		

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A 901	Continued From page 5 for basic activities of daily living and transfers. Resident #1 was hospitalized from 12/12/23 - 12/15/23 for respiratory symptoms following a pneumonia diagnosis on 12/7/23, and a new diagnosis of pulmonary hypertension. In preparation for discharge from the hospital an Occupational Therapy (OT) assessment was conducted on 12/14/23. This assessment indicated Resident #1 was capable of transfers with one staff providing moderate to maximum assistance and another staff standing by for safety. Discharge to a subacute rehab facility (SAR) to restore strength and endurance, and to improve independence with transfers and activities of daily living was recommended by the Occupational Therapist. Resident #1 was not in agreement with discharge to a SAR, and the Assisted Living Residence agreed to readmit Resident #1 with a requirement to use a Hoyer mechanical lift for all transfers as a condition of return to the home. The facility's readmission plan for Resident #1 was to remain in bed with staff providing frequent checks, range of motion exercises, repositioning every 2 hours, and use of a bedpan and depends while awaiting a Physical Therapy evaluation on 12/19/23 to determine transfer status for resident and employee safety. On 12/19/23 the Physical Therapist noted the facility's nursing staff "has been struggling for some time with assistance with transfers, and management has now insisted a Hoyer lift be used for all transfers with no option to transition back to any type of other transfer." The PT assessment stated Resident #1 was "distraught regarding no longer having the opportunity to stand or transfer"; and "distressed regarding this expediating his/her loss of strength and mobility". The PT noted Resident #1 was willing to use the Hoyer lift for transfers from bed to wheelchair and	A 901		

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A 901	Continued From page 6 recliner with a goal of regaining the ability to use a grab bar to pull to stand for personal care and toileting, and recommended staff assist Resident #1 with standing at the grab bar with an eventual goal of resuming use of the bar for toileting. The PT noted the facility's response was that staff could not safely assist with this recommendation "at any time moving forward". During the course of the survey on 1/24/24 the Director of Health Services and Direct Care Staff expressed concerns for Resident #1's safety and indicated risk for staff injury was a factor in the decision to require a Hoyer for transfers. On the afternoon of 1/24/24 Resident #1 expressed s/he refused the recommended discharge because s/he feared the Sub Acute Rehab environment. Resident #1 stated s/he understood use of the Hoyer lift for transfers from the bed to the wheelchair, however s/he wanted to be allowed to practice standing up using the grab bar, to use a commode, and to be able to transfer independently from wheelchair to recliner.* Per record review, Resident #1's record did not include a Negotiated Risk Agreement related to Resident #1's decision to return to the home on discharge from the hospital on 12/15/23 instead of following the hospital's recommended plan for further treatment at a Sub Acute Rehab facility; and related to the facility's determination that a Hoyer lift was required for all transfers which was not consistent with the assessments and recommendations of the hospital's Occupational Therapist and the Home Health Physical Therapist. During an interview commencing at 12:24 PM on 1/24/24 the Director of Health Services confirmed the use of a Hoyer lift was determined to be	A 901	A901 [*of note: Per Resident/Therapy-Independent transfers have not been a goal] Upon 12/15/23 hospital discharge, Resident was informed of need for Mechanical lift transfers for safety of resident and staff due to variable abilities r/t disease process (MS)/weakness. Per documented conversation with Resident 12/20/23, Resident was electing to remain at Mansfield Place over exploring options for a community which could provide a higher level of care/may be able to accommodate standing transfers. 2/19/24 NRA reviewed with resident and signed. This included, but was not limited to addressing: -Risks of using a FBM lift -Limited movement/increased time in bed can make skin vulnerable to damage and lead to the development of pressure wounds. -Staff will maintain safety by providing care in bed as needed and offering routine assistance with turning and positioning to maintain skin integrity. -Because of more limited mobility/decreased activity—at risk for muscles to lose mass and strength. -Recommendations for resident to promote optimal health status: -Wear long sleeves whenever possible related to thin/fragile skin and use of mechanical lift sling. -Maintain a home exercise program to increase strength and maintain muscle mass. (reviewed options for elective services e.g. hired PT therapy/personal trainer as HH PT services ended Feb/2024) -Continue with pulmonary hygiene and deep breathing exercises.	

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A 901	Continued From page 7 necessary by the facility to prevent resident and staff injuries during transfers on return from the hospital on 12/15/23 and stated Negotiated Risk Agreements were not on file in Resident #1's record.	A 901	HSD Continuing education: completed 3/11/24 March 2024- Relias E-Course Risk Management (NRA) Summary: When persons living in care facilities choose to engage in activities that put themselves or others at risk of harm, health care providers must find approaches to support both Resident autonomy and the safety of Residents and others. Living at risk is best addressed by analyzing the risks involved, considering all options available to reduce risks to a tolerable level, and implementing interventions based on the ethical principles of respect for autonomy, non-maleficence, and beneficence. Risk can never be fully eliminated, and all people choose to live with some degree of risk. When health care providers support Residents who choose to live at risk, a terrible outcome, including death, may occur. While this must be acknowledged as a risk inherent in Resident-centered care, energy should be directed to ensuring that risks of harm are reduced to a tolerable level. Moving forward: Nursing Management team to review situations on a case by case basis utilizing best practice principles of NRA/Resident centered care using systematic approaches Additionally, all Residents returning to Mansfield Place against recommendation of hospital will require NRAs to address choices/risks -Process presided over by HSD/RN A901 Plan of Correction accepted by Jo A Evans RN on 3/15/24.	ongoing