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

October 16, 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 **August 20, 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 08/20/2024

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: On 8/19/24 and 8/20/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey, and investigation of one facility reported incident and one complaint. There were no regulatory deficiencies identified related to the facility reported incident. The following regulatory deficiencies were identified related to the relicensure survey and the complaint investigation:	R100	Mansfield Place these matters seriously and is committed to addressing any areas of growth and development identified in order to provide the level of care and services each resident deserves and is entitled to.	
R126 SS=D	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 interview and record review, the home failed to ensure services are provided to meet each resident's nursing needs for a resident who was at high risk for falls (Resident #1). Findings include: The facility's Resident Care Falls Policy states all residents will be on safety checks on the overnight shift; and the facility's written instructions for resident care on the night shift states 2-hour checks are to be completed. Per record review, Resident #1's diagnoses included Dementia and multiple cardiovascular	R126	R126 This issue was identified as a singular occurrence To prevent recurrence, Mansfield Place has: -HSD investigated/reviewed situation Employee who did not follow protocol was terminated by manager. -8/25/24 HSD introduced broad safety check re-education -- initiated for all overnight caregivers to include a review of expectations of systemic measure re: proactive/purposeful rounding as designated in EHR, but at least every 2 hours	6/18/24 9/5/24

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Ellis, RN
TITLE: General Manager
(X6) DATE: 10/7/24

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 08/20/2024

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
R126	Continued From page 1 conditions. Four Falls Risk Assessments completed between 2/27/24 - 4/3/24 determined Resident #1 was at high risk for falls. Resident #1's Plan of Care identified his/her risk for falls related to unsteady gait, and history of falls due to impulsivity and poor safety awareness. His/her Care Plan included safety checks as an intervention. On the morning of 5/17/24, Resident #1 was scheduled for a safety check at 5:00 AM which was documented as completed by a Staff member at 5:14 AM on 5/17/24. An Unwitnessed Fall Incident Report states upon entering Resident #1's apartment at 6:17 AM the Staff member found the resident lying face down across his/her bed. Per the Unwitnessed Fall Incident Report, when the Nurse on duty responded to the Staff member's call for assistance Resident #1 was "blue in color, unresponsive and making loud snoring sounds", and had signs of an injury on the left side of his/her head. Per record review Resident #1 was transported via ambulance to the Emergency Department, with findings of an intracranial hemorrhage on the right side of his/her head, and extensive left scalp edema (swelling) following assessment. Resident #1 was transferred to a respite facility for end-of-life care and passed away on 5/24/24. While the hospital discharge summary indicates Resident #1 presented to the Emergency Department after a traumatic fall, it is important to note the timing of onset and cause of Resident #1's right sided hemorrhage and swelling on the left side of his/her head were not identified. Per interview with the Director of Health Services commencing at 3:56 PM on 9/19/24, review of	R126	Type text here R126 Continued 9/30/24- HSD initiated monthly randomized safety check audits performed in person or virtually to ensure ongoing oversight/compliance. by HSD/Designee. Continuing re-education and disciplinary action to follow as needed to maintain established standards. R126 Plan of Correction accepted by Jo A Evans RN on 10/14/24	Ongoing

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 08/20/2024

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
R126	Continued From page 2 surveillance footage of the area outside Resident #1's room showed the safety check documented by the Staff member as completed at 5:14 AM on 5/17/24 did not occur. Per record review safety checks were not completed between 2:34 AM and 6:17 AM. Furthermore, a Facility Employee Coaching/Counseling Record states the Staff member delayed reporting Resident #1's unwitnessed fall incident on 5/17/24 and failed to fully divulge all available information. Per interview on the afternoon of 8/19/20, the Director of Health Services stated this incident "was not handled correctly"; and confirmed the Staff member falsely documented completion of Resident #1's safety check on the morning of 5/17/24. Please refer to tag 213	R126		
R179 SS=F	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 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;	R179	R179 -8/21/24- Re-evaluation of mandatory training content. Revised and Reissued to care staff by General Manager to include modules which cover all required content including, but not limited to CPR, First aid, Resident Rights, Fire Safety, etc. HSD/designee to ensure annual completion via monthly auditing	9/1/24 ongoing

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 08/20/2024

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
R179	Continued From page 3 (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 there was a failure to ensure completion of all required trainings for 5 out of 5 sampled staff. Findings include: The facility's policies and procedures include a listing of required training modules. Per review of training documentation on file and available for review on request, 5 out of 5 sampled Staff did not complete all required yearly trainings. These findings were confirmed by the General Manager and Director of Health Services at 3:45 PM on 8/19/24.	R179	Revised education content includes, but is not limited to: -First Aid for Home Caregivers -Promoting ADL Independence -Basics of CPR -Cultural Competence and Healthcare -Care of Residents With Dementia In AL -Behavioral Challenges in Residents -Infection Control: Handwashing -Handling Dirty Linens: Residential and Care Areas -Disaster and Evacuation -Donning and Doffing PPE -Bloodborne Pathogens -Understanding Trauma-Informed Care -Communication -HIPAA -Essentials of Resident Rights -Recognition to Prevention: Addressing Abuse Effectively -Elopement/Wandering -Infection Control: Basic Concepts -Disaster Preparedness: Essentials/Fire -Dementia Experience (interactive) R179 Plan of Correction accepted by Jo A Evans RN on 10/14/24	
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by:	R190	R190 Review of all background checks including VT criminal, Abuse Registries, and multi-state checks performed by Employee Development Manager for all existing staff Employee Development to continue self auditing for all new hires and follow most updated policy Re: annual background checks (triggered by anniversary date)	9/14/24 ongoing

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 08/20/2024

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
R190	Continued From page 4 Based on staff interview and record review there was a failure to complete all required criminal record and abuse registry checks for 3 out of 5 sampled staff. Findings include: The facility's policies and procedures have been updated to include regulatory requirements for completion of Vermont and National criminal record, and adult and child abuse registry checks as required. Per review of documented completion of criminal record and abuse registry checks on file and available for review on request on the afternoon of 8/19/24, criminal record and abuse registry background checks were not completed as required for 3 out of 5 sampled Staff. These findings were confirmed by the Employee Development Manager at 9:35 AM on 8/20/24.	R190	(addressed on page 4) R190 Plan of Correction accepted by Jo A Evans on 10/14/24.	
R213 SS=D	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 interview and record review there was a failure to ensure the right to dignity and privacy for one applicable resident (Resident #1) related to Staff photographing the resident in a vulnerable position during a critical medical emergency. Findings include:	R213	(Response on page 6)	

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 08/20/2024

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
R213	Continued From page 5 The facility's Abuse and Neglect Policies and Procedures Manual Sign -off states, "Every resident will be treated with respect and dignity at all times." The facility has a policy on file which strictly prohibits employee use of a cell phone in the facility without permission granted by the Executive Director. Per record review, on the morning of 5/17/24 Resident #1 was found lying across his/her bed, face down with his/her face positioned off the side of the bed following what was documented as an unwitnessed fall. Resident #1 was transported to the hospital with clinical findings following assessment which indicated an intracranial hemorrhage on the right side of Resident #1's head, extensive left scalp edema (swelling), and a urinary tract infection. Per internal investigation notes related to this incident, on 6/14/24 it was reported to the Director of Health Services (DHS) that the Staff who found Resident #1 on the morning of 5/17/24 used his/her personal phone to photograph Resident #1 positioned face down on his/her bed during this critical medical incident and shared this photo with another Staff. An Employee Coaching /Counseling Record dated 6/18/24 states the Staff was not "immediately forthright with [his/her] manager (on both 5/17/24 and 6/14/24) regarding ... improper use of personal cell phone to photograph a resident." At 4:14 PM on 8/19/24 the DHS confirmed the Staff took a picture of Resident #1 lying in the bed and showed it to another staff. On the afternoon of 8/19/24 the DHS stated the photo was erased upon discovery and employment of the Staff member who was discovered to have taken the photo was	R213	R213 As noted employee who did not follow protcol was terminated. 10/1/24-Additional educational Module issued to all care staff specific to Resident Rights and photography of Residents. Issued by HSD. R213 Plan of Correction accepted by Jo A Evans RN on 10/14/24	10/6/24

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 08/20/2024

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
R213	Continued From page 6 terminated. Please refer to tags 126	R213		