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

July 24, 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 re-licensure survey conducted on **May 9, 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

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 _____	05/09/2023

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 conducted on 5/9/23 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 resident, family and staff interviews, the ALR (Assisted Living Residence) failed to ensure a resident with a disability consistently received the necessary care and services to maintain their limited independence. (Resident #1) In addition there was a failure to ensure a resident's safety needs were met for one applicable resident who requires increased supervision and monitoring due to a recent history of wandering. (Resident #2) Findings include: 1. Per record review, Resident #1 is sight impaired and is considered legally blind, has an unsteady gate, a past history of falls and requires a walker when ambulating. In order for Resident #1 to move about the ALR s/he requires a staff escort to the dining room and to activities guiding her/him around obstacles or people. However, per interview at 4:10 PM on 5/9/23, Resident #1	R126	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Ellis, RN 7/21/2023, 7:47:24 AM | TITLE | (X6) DATE: 05/31/23

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R126	Continued From page 1 stated s/he has experienced in the past few months times when s/he was brought to an activity or was placed outside to enjoy the good weather and although s/he pressed her/his pendant to request assistance to return inside to his/her apartment, staff failed to respond for extended periods of time. Resident #1 recalled being assisted outside on one occasion, and upon using his/her call pendent to seek assistance back into the facility staff failed to arrive to provide an escort. After a significant period of time the resident attempted to find her/his way back to the ALR building but was not aware of surroundings and which way to navigate. Eventually, Resident #1 was found by staff and returned, however s/he stated the incident created increased anxiety and fear. Resident #1 also stated s/he is hesitant to participate in activities, which s/he often has enjoyed. The resident further stated staff would escort her/him to an event/activity but failed to respond when requesting assistance for an escort to return to her/his apartment. Resident #1 stated other residents have been kind in providing her/him assistance to return to her/his apartment. In addition, the resident has a talking clock attached to his/her walker which provides the resident with an accurate time line when seeking assistance, knowingly aware of the lapse of time when a request is made. Resident #1 also confirmed s/he has an evening routine which also requires staff assistance. Although Resident #1 expressed his/her need to remain independent, staff are needed to help choose his/her clothes for the next day, help with some of the evening care. However, especially on the weekends despite pressing his/her pendent for assistance, staff fail to come to his/her apartment. As a result, Resident #1 stated s/he	R126		

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R126	Continued From page 2 attempts to do some self care and makes his/her way to bed without receiving help with evening care. Presently Resident #1's vision is limited to shadows and some shapes. 2. Resident #2 has a history of dementia which has progressed over the past 2 months. The resident has experienced unwitnessed falls over the past 6 weeks and incidents of wandering have occurred. Per record review, Resident #2 was found in the late evening on 3/31/23 wandering on the 3rd floor attempting to find the elevator to go home. On 4/17/23 Resident #1 had left the building and was found walking toward a CVS pharmacy and required assistance to return to the ALR. On 4/20/23 & 5/8/23 incidents of wandering, utilizing the elevator and attempting to exit the building occurred with Resident #2 seeking to find "...the assessors office". Although the family has been made aware of the increased confusion and exit seeking, a closer monitoring of Resident #2 has not been facilitated by the ALR to meet the resident's present safety needs. Per interview at 4:10 PM, the Director of Operations acknowledged concerns regarding Resident #2's wandering. Presently, the concierge at the front entrance, who carries multiple responsibilities at the busy facility, has been made responsible to monitor Resident #2's if s/he exits the building and/or decides to go outside and sit on a bench. When asked if additional frequent monitoring checks could be incorporated to ensure the resident's safety, the Surveyor was informed "...we can't do that, it is not realistic".	R126		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services	R179	See Attached	

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R179	Continued From page 3 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; (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 record review and confirmed by staff, there was a failure by the ALR to complete the required 12 hours of mandatory annual training. for 3 out of 5 staff. Findings include: During the course of survey on 5/9/23, the Administration was requested to demonstrate via training records that staff employed at the ALR who provide direct care to residents had received the 12 hours of required yearly training to include: Resident Rights; Fire Safety; Mandatory	R179		

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R179	Continued From page 4 Reporting, Infection Control, Emergency Response, Respectful Interactions and General Supervision. The RN in the afternoon of 5/9/23 confirmed the trainings were not completed by the 3 out of 5 staff whose education records were reviewed.	R179		
R220 SS=C	VI. RESIDENTS' RIGHTS 6.8 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, there was a failure to include in the ALR grievance policy & procedure specific time frames for addressing and completing a review and response to a complainant. Findings include: Per review of the ALR's Complaint and Compliment Procedure last revised 1/20 directs an individual to contact the ALR's Executive Director with a complaint. The policy does not provide a time frame for when the complaint	R220	See Attached	

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R220	Continued From page 5 would be reviewed and processed to include a specific time frame for a response to the complainant by the Executive Director.	R220		
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 observation and staff interviews there was a failure to ensure all perishable food and drinks were labeled and dated. Findings include: During a tour of the facility kitchen and food service areas commencing at 09:57 AM on 5/9/23 the following perishable food items were observed and confirmed by the food services manager to be improperly stored: In the reach-in refrigerator, on the Memory Care unit multiple items were not labeled as to when they were opened. These items include a half gallon of milk, 2 half gallons fat free milk, 1 half gallon of silk almond milk, 11.3 oz jar of mayonnaise, 2 12 oz containers of mustard, 1 5 oz jar of red-hot sauce, 14 oz container of whipped cream, 8 oz container of chocolate syrup, and 20 oz container of ketchup. In the facility kitchen walk-in refrigerator 1 gallon container of BBQ sauce, 2 qt container of soy	R247	See Attached	

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R247	Continued From page 6 sauce, and 1 64 oz container of sweet teriyaki sauce were noted to be open. In the reach-in refrigerator 4 half gallons of milk, 2 1 qt containers of half and half, and 2 containers of mustard were noted to be open and undated. This was confirmed by the food services manager at time of observations.	R247		
R258 SS=C	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure trash cans in the kitchen area remained covered. Findings include: During a tour of facility kitchen area commencing at 10.49 AM on 5/9/23 observations noted three plastic trash cans located in food prep area were uncovered. This was confirmed by the food services manager at the time of observation.	R258	See Attached	
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a	R266	See Attached	

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R266	Continued From page 7 safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there was a failure of the ALR to provide and maintain care in a safe environment for residents residing on the Memory Care Unit. Findings include: During the environmental tour of the ALR's Memory Care Unit on 5/9/23 beginning at 10.00 AM and accompanied by the Health Services Director & the Director of Operations, a housekeeping cart was observed unattended outside of a resident's room. The cart contained the following cleaning agents of concern: 1. Dual Blend #19 Lavender 256 neutral disinfectant cleaner & deodorizer. Per the Safety Data Sheet (SDS) this cleaning agent can be a health hazard causing acute dermal & oral toxicity. It also can cause serious eye burns and eye damage if contact is made with the cleaning agent. 2. Zep General Disinfectant SDS lists warnings of eye irritation with possible splashing can create irreversible eye damage, and in case of skin contact the skin must be washed off immediately and continue washing for at least 15 minutes. At 10.45 AM the same cart was later observed unattended in a hallway with accessible cleaning solutions in a hallway near an exit door on the unit. The Memory Care unit is the residence for individuals with dementia who ambulate and wander throughout the unit. Presently the ALR utilizes a housekeeper cart that can not be locked resulting in unsafe storage of harmful cleaning	R266		

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R266	Continued From page 8 agents, allowing accessibility to vulnerable residents, which has the potential for harm. The observations were confirmed by staff who had accompanied the surveyors at the time of the tour.	R266		

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

Plan of Correction for survey completed: 5/9/23

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 Resident Care and Home Services 5.5 General Care.	Mansfield Place acknowledges and takes seriously our obligation to meet resident's personal, psychosocial, nursing, and medical care needs:			
	• Resident #1's Care plan and ISP (Individualized Service Plan) was evaluated for content/ accuracy by the clinical team. Review was initiated with members of the direct care team. Additional ISP/care sheet revisions-All reviewed with caregiver/ nursing team to address daily routine and care expectations for all shifts including weekends and evenings.	5/9/23-5/24/23	• Issue addressed on 5/9/23. Updated ISP reviewed by all members of direct care team. Care plan revisions ongoing, and available for review by care staff in EHR.	• Members of the licensed nursing team. Licensed nursing team will continue to update ISP on an ongoing basis-annually and by exception.
	• 5/16/23- Resident/family care conference with resident, family, Health Services	5/16/23	• Care Coordinator/ HSD will continue to offer care plan meetings	• Health Services Director (HSD) will continue to monitor for compliance: Offering of

	Director (HSD), and primary nurse, to discuss care needs and goals as well as determine reasonable timeframe expectations for escorting		annually and PRN for any significant changes in care needs/status and/or concerns. • The Health Services Team will continue to work towards establishing timely and realistic response intervals for escort retrievals to/from locations so that preferences are observed, and safety maintained to the best of our abilities, and evaluate response timeframes as needed—Ongoing.	annual/PRN care plan meetings and resident satisfaction with care-ongoing. • HSD or designee to monitor response timeframes as needed for any concerns. .
	• 5/12/23 Activities Referral template created to address socialization/ activity preferences and supplemental aids needed.	5/12/23	• 5/12/23 activities referral submitted by nursing to Life Enrichment Director (LED) for Resident #1 to assist in determining their preferences /support requirements.	• Moving forward, Nursing to submit Activities Referrals PRN and LED or designee to promptly review and submit referrals to clinical team.
	• Mansfield Place wholly acknowledges	5/27/23	• 5/27/23- Director of Operations-	• Clinical Management team to follow

	our obligation to and responsibility in keeping residents safe: Resident #1 revealed that it was an employee of third-party provider who had brought them outdoors last summer.		addressed this incident with the Business Development Officer of the external organization with request to not have this particular employee provide services per resident request. Also reiterated that their staff should be certain to update the front desk attendant if they leave a resident outdoors after a session as this can pose a safety risk if the resident has a physical impairment or condition such as blindness which does not allow them to easily navigate back indoors independently.	up with 3rd party provider as needed for any future issues.
R126 V.	Resident #2 • Prior to survey: 5/2/23-Care conference with family and hospice to discuss concerns for Resident #2's safety at an assisted living level. Family, Hospice, and Mansfield Place nursing in	5/9/23	Mansfield Place will continue with current measures, and in addition: • While Mansfield Place maintains that staff appointed 1:1 and 15-minute checks are not a reasonably	• Ongoing-The HSD will continue to routinely monitor documentation compliance with tasks

	attendance. Family members were actively looking into 1:1 care and discussing a potential move to secure memory care based upon their financial capabilities and availability of apt. There had been ongoing coordination with Hospice MSW and RN who had continued with outreach efforts to obtain hospice volunteers and discuss 1:1 needs with family; although, no additional support came to fruition.		sustainable option in this setting, routine safety checks were in place in EHR during the hours with the least amount of available staff oversight. • 5/9/23 Nursing team Increased frequency of safety checks initiated which included around the clock monitoring. *Resident has since been transitioned to secure memory care environment (7/14/23)	scheduled in EHR.
	• 5/12/23- Activities consult requested to specifically address diversional activities and interventions to curb wandering behaviors- completed.	5/12/23	• 5/12/23 activities consult submitted by nursing team to LED for Resident #2 to address activity preferences and support needed to deter wandering.	• Moving forward, HSD will oversee activities consults so that they may be submitted in a timely manner to address resident safety and/or recreational needs.
	• 5/13/23- Negotiated risk	5/13/23	• 5/13/23- Negotiated risk	• Moving forward, HSD

	enacted-to review approaches in place to minimize risks and potential consequences (of which had previously been reviewed at 5/2/223 care plan meeting). The family has consented to this plan as outlined in the Negotiated Risk Agreement.		enacted for Resident #2.	will promptly initiate Negotiated Risks to minimize potential risks and consequences of unsafe behaviors.
	• As part of the Mansfield Place interdisciplinary team--the concierge, while not solely accountable, continued to participate in the general observation of resident as needed in the case that resident #2 elected to exercise their resident rights and to sit on patio directly in front of window. The concierge also continued to update the Health Services Team to place nursing on alert so that team members could increase frequency of unscheduled checks if resident elected to utilize front	5/9/23	Mansfield staff to continue with current measures in place in addition to new interventions as outlined in this POC. • The staff preferred and recommended location for resident #2 to enjoy the outdoors is enclosed memory care patio if #2 was willing to comply.	The Interdisciplinary team will continue to collaborate to support safety efforts.

	patio when staff were unavailable to provide a dedicated 1:1 oversight due to tending to other resident's needs and/or emergency situations.			
	• 5/15/23-family purchased mobile GPS wristband per staff request as an added safety measure.	5/15/23	• Every shift GPS placement task scheduled in EHR.	• The HSD will continue to routinely monitor documentation compliance with tasks scheduled in EHR.
	• 5/16/23-Global response: Binder at front desk compiled to facilitate staff identification and list first line interventions for residents who have been identified by nursing team as being a more significant wander risk.	5/16/23	• Concierge staff were made aware of Binder at front desk compiled to facilitate staff identification and list first line interventions.	• LED incorporated education regarding Wander Binder into new hire training. • HSD and LED to maintain binder for accuracy.
			• Licensing nursing to continue with Wander Risk assessments upon admission and PRN.	• HSD to continue to routinely monitor Assessments for compliance via EHR.
	• 5/23/2023 Global response: Wandering Risk Assessment template revised to	5/23/23	• Wandering Risk Assessment template revised in EHR by clinical manager.	• Clinical team to ensure Wander Risk Assessments are promptly performed on

	prompt a more structured approach to wandering/Wander Action Sheet formulated to ensure appropriate follow up and interventions are utilized for residents identified as higher risk.		• 5/23/23-New Wander Risk Assessment and Wander Action Sheet completed for resident #2.	admission and as needed. • Wander Action Sheets to be completed based on nursing judgement-All overseen by HSD.
	• 5/24/23 Nurse education re: Updated Wander Risk assessment template/Wander Risk action plan form initiated to better evaluate/implement strategies and interventions--Initiated/ ongoing.	5/25/23	• 5/25/23-Nurse education/Inservice re: Wander risk concerns and interventions with all care staff—Initiated/ ongoing.	• Nurse education/Inservice re: Wander risk concerns and interventions-HSD to ensure ongoing education as part of routine new hire training. • Moving forward, nursing to use revised Wander Risk template (integrated in EHR) overseen by HSD.
	• 5/25/23-Caregiver education/Inservice re: Wander risk concerns and interventions with all care staff.	5/25/23	• 5/25/23-Caregiver education/Inservice re: Wander risk concerns and interventions with all care staff—Initiated/ ongoing.	• Moving forward, Caregiver education-HSD to ensure ongoing education as part of routine new hire training.

	Of note-Global measure: We continue to await implementation of our upgraded call system which includes geo-fencing capabilities. Due to be installed by August 2023. **Tag R126 POC accepted on 7/24/23 by P. Cota**	TBD-installation pending.	• Geofencing will serve to increase general resident oversight/ location monitoring in our community.	• Clinical Management team to oversee in conjunction with facilities Director once installed.
R179-RESIDENT CARE AND HOME SERVICES 5.11b Staff Services-Mansfield Place will ensure that at each staff person providing direct care receives at least twelve (12) hours of training each year	• 5/10/23-Review of staff training logs—Initiated/ ongoing. **Tag R179 POC accepted on 7/24/23 by P. Cota**	5/10/23-ongoing	• New process has been implemented to ensure all mandatory training is accomplished by hire anniversary date and must be completed in order for staff to be eligible for annual merit increases, ad continued employment.	• Employee Development Manager to audit compliance on at least a weekly basis. Departmental managers to enforce their departmental staff's compliance.
R220- VI. RESIDENTS' RIGHTS	Mansfield Place will ensure that the grievance procedure includes a published time frame for responding to residents. • 5/10/23 Procedure updated to reflect response time of responding to a grievance within 7 business days.	5/10/23	• Procedure updated and published by Executive Director.	• HSD to ensure that all grievances are addressed within established timeframe.

Tag R220 POC accepted on 7/24/23 by P. Cota

R247- VII. NUTRITION AND FOOD SERVICES 7.2b Food Safety and Sanitation	Mansfield Place will ensure that all perishable food and drinks are labeled and dated. • 5/9/2023-Food Services Director (FSD)/Memory Care Coordinator (MCC) performed full evaluation of all refrigerators for any opened/undated items. • 5/11/23-5/23/23 Broad education of all kitchen and memory care staff to address importance of labeling and dating of all opened perishable foods-initiated and completed. • Formal refrigerator audits introduced.	5/9/23 5/11/23 5/23/23	. • Immediate full audit • Broad education of all kitchen and memory care staff completed. • 5/23/23-Audits to be completed at least QOD to ensure regulatory compliance—Initiated/ ongoing.	• FSD/MCC completed audits. • Education administered by FSD/MCC • Audits completed by FSD/MCC per established guidelines and HSD to collect/oversee audits on at least a weekly basis.
7.3h Food Storage and Equipment	Mansfield Place will ensure all garbage is collected and stored properly. • 5/10/23-Dropshot auto-closing affixed	5/10/23	• Drop shot lids installed.	• FSD to ensure lids remain functional and permanently affixed to trash cans

Tag R247 POC accepted on 7/24/23 by P. Cota

	trash can lids were ordered.			
R266-PHYSICAL PLANT 9.1a Environment	Mansfield Place will provide and maintain a safe, functional, sanitary, homelike, and comfortable environment.			
	• 5/9/23 Same day verbal education to all housekeepers and Memory Care staff re: Importance of chemical safety and keeping all cleaners out of reach of cognitively impaired residents. Bins were placed on carts to house all cleaners and facilitate mobility of chemicals so that staff may always keep within line of sight/out of reach of vulnerable residents.	5/9/23	• chemical safety education/storage expectations inservice initiated with housekeeping dept.	• Education ongoing as part of new hire training process overseen by HSD and Facilities Director for respective departments.
	• Broad chemical safety education/storage expectations inservice initiated with housekeeping and Health Services dept Initiated 5/10/23-Completed 5/14/23.	5/14/23	• chemical safety education/ storage expectations inservice formally initiated with housekeeping dept.	• Education completed by Facilities Director/HSD
	• 5/9/23-handled totes	5/12/23	• Handled totes for chemical	• Facilities Director or

	purchased to assist in chemical portability-these have arrived and were implemented on all carts.		portability-arrived and were implemented on all carts by Facilities Director	designee to ensure totes are being properly utilized (accomplished via routine audits)
	• 5/13/23-Daily environmental audit for any potentially unsafe chemicals to include common areas and any unattended housekeeping carts.	5/13/23	• Environmental chemical safety storage audits. ensure daily environmental audit for any potentially unsafe chemicals to include common areas and any unattended housekeeping carts.	• Facilities Director and MCC or designee HSD to collect/ oversee audits-Audits periodically spot-checked for compliance and collected weekly for review/follow up.

‘= **Tag R266 POC accepted on 7/24/23 by P. Cota**