

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  Mansfield Center for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Warren Circle Storrs Mansfield, CT 06268	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47460</p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for medication administration, the facility failed ensure medications were administered in accordance with physician orders, failed to ensure a medication was administered in accordance with physician orders. The findings include:</p> <p>Resident #1's diagnoses included essential tremor.</p> <p>Review of hospital discharge orders dated 6/21/2024 directed Propranolol (used to tremors) 60 milligram (mg) 24-hour capsule by mouth daily.</p> <p>Physician order dated 6/21/2024 directed administer Propranolol HCL oral tablet 60 milligrams (mg) give one by mouth daily to start on 6/22/2024.</p> <p>Review of the June 2024 Medication Administration Record (MAR) identified the Propranolol HCL oral tablet 60 mg was administered on 6/22/2024 at 9 AM.</p> <p>Additional record review failed to identify Resident #1 received the Propranolol 60 mg 24-hour capsule by mouth daily, and identified Resident #1 received Propranolol HCL oral tablet 60 mg (a non-24-hour dose).</p> <p>Interview and record review with the DNS on 7/18/2024 at 11:15 AM identified when Resident #1 was being discharged from the facility, he/she notified the facility that he/she was given non-extended-release Propranolol during his/her stay. The DNS stated an investigation was conducted and identified on 6/22/2024 Resident #1 did not receive the 24-hour capsule. The DNS stated the error was a transcription error, and the Propranolol administered was obtained from the facility emergency supply, and staff were provided with education after the error was identified.</p> <p>Although requested, a facility policy regarding transcribing orders was not provided for surveyor review.</p> <p>Facility documentation review identified staff education was initiated on 6/27/2024 regarding transcription of physician orders. Audits were initiated on 7/12/2024, and a QAPI meeting was held on 7/12/2024. Based on review of facility documentation, past non-compliance was identified.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. A physician order dated 6/21/2024 directed to administer Bupropion HCL ER (XL) 150 mg oral tablet extended release 24 hours, by mouth daily.</p> <p>Review of the June 2024 MAR identified Resident #1 did not receive the Bupropion HCL ER (XL) 150 mg oral tablet extended release 24 hour, on 6/22/2024 at 9:00 AM in accordance with physician orders.</p> <p>Interview and record review with the DNS on 7/18/2024 at 11:15 AM identified the Bupropion HCL ER 150 mg was omitted in error on 6/22/2024 at 9 AM. The DNS stated the medication had not been received from the pharmacy and there was none in the facility emergency supply.</p> <p>Facility documentation review identified staff education was initiated on 6/27/2024 regarding transcription of physician orders. Audits were initiated on 7/12/2024, and a QAPI meeting was held on 7/12/2024. Based on review of facility documentation, past non-compliance was identified.</p>		