STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075402	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Center for Nursing and Rehabilitation	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for hospitalizations, the facility failed to notify the provider timely of a change in condition leading to a hospitalization. The findings include: Resident #1 's diagnoses included hemiplegia and hemiparesis (paralysis and/or weakness) following a cerebral infarction (ischemic stroke where the blood flow to the brain is blocked) affecting the left dominant side and dysphagia (difficulty swallowing) following a cerebral infarction. The Admission/readmission Evaluation dated 8/27/24 identified that Resident #1 was cognitively intact and did not exhibit any Activities of Daily Living (ADL) impairments. Additionally, it identified that Resident #1's lung sounds were diminished on both the right and left sides and no cough was noted. The Resident Care Plan (RCP) dated 8/28/24 identified that Resident #1 had a deficit in self-care functioning and decreased mobility secondary to cerebral vascular accident with interventions that included to provide staff set-up for eating. A nurse's note dated 8/30/24 at 2:58 identified that Resident #1 was noted with a non-productive cough (a dry cough that doesn't produce mucus or phlegm) and crackles (abnormal lung sounds) were heard when auscultating (listening) to lung sounds. A nurse's note dated 8/31/24 at 10:23 PM identified that Resident #1 was noted with a productive cough (producing mucus or phlegm), a moderate amount of white secretions and crackles were heard when auscultating lung sounds. A nurse's note dated 9/1/24 at 10:31 PM identified that Resident #1 was noted with a productive cough, a moderate amount of white secretions and crackles were heard when auscultating lung sounds. The note reported that the resident had a body temperature of 99.4 degrees Fahrenheit (low-grade fever) and Tylenol (fever reducer) was given with good effect. A nurse's note dated 9/2/24 at 10:45 PM identified that Resident #1 was noted with a productive cough, a moderate amount of white secretions and crackles were heard when auscultating lung sounds. The note reported that the resident denied any shortness of breath and the head of the bed was elevated. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075402	A. Building B. Wing	01/02/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An SBAR (Situation, Background, Assessment and Recommendation) form (a reporting tool for a change in condition) dated 9/3/24 at 6:40 PM identified that Resident #1 was noted with an altered mental status and a fever, reporting increased confusion and requiring more assistance with Activities of Daily Living (ADLs). A transfer form dated 9/3/24 identified that Resident #1 was alert but disoriented and able to follow simple commands but reported that the resident had a body temperature of 100 degrees Fahrenheit and an oxygen level of 91% on room air. It identified that the provider was notified, and the resident was sent to the ED for evaluation at 7:00 PM. Review of progress notes from 8/30/24 through 9/2/24 failed to identify that the provider was notified that Resident #1 had a change in condition as noted in the 8/30/24, 8/31/24, 9/1/24 and 9/2/24 nurse's notes until 9/3/24 (4-days after the initial observation) when the resident was noted with a fever, decreased oxygen level and altered mental status. Review of hospital progress note dated 9/8/24 identified that Resident #1 arrived to the ED on 9/3/24 with an oxygen level of 90% on room air, a body temperature of 101.9 degrees Fahrenheit and a heart rate of 104 (all irregular). It identified that blood work and a chest x-ray were obtained and signified an infection, reporting a probable aspiration pneumonia (lung infection that occurs when a person inhales food, liquid, saliva or stomach contents into their lungs instead of swallowing) as etiology for acute hypoxemic respiratory failure, identifying that the resident was treated with antibiotics. The report identified that the resident stated he/she had been coughing for a while. Interview with APRN #1 on 1/2/25 at 2:12 PM identified that if Resident #1 had developed a productive cough and abnormal lung sounds, she would expect that a provider be notified immediately. She reported that she could not recall being notified regarding a change in respiratory status with Resident #1 but identified that all providers document their communication with nursing in the clinical record, and if the provider doesn't see the resident in person, it's documented as a 'Telemedicine Visit'. She reported that if both nursing and the provider didn't document a communication, it was unlikely that the provider was notified. APRN #1 identified that if she had been notified of Resident #1's change in status, she would have most likely ordered a chest x-ray. Interview with RN #1 (previous DNS) on 1/2/25 at 3:13 PM identified that nursing should have notified the provider immediately regarding a resident with a change in lung sounds and/or the development of a productive cough. She identified that she was unaware that nursing had documented that they had observed crackles and a productive cough several days prior to Resident #1 being transferred to the hospital on 9/3/24 and was unsure why they had not notified the provider. Review of the Change of Condition Notification policy dated 4/2023 directed, in part, that the facility will inform the resident's healthcare provider when there is a change of condition. When the staff identifies a change in condition, they will notify the licensed nurse and the licensed nurse, per state regulations, will conduct a complete physical/mental evaluation and document the findings in the medical record including the resident's reactions to symptoms. The licensed nurse per state regulations notifies the resident, the attending physician and the family/responsible party of the change in condition. The facility must inform the resident's healthcare provider when there is an incident involving the resident which may result in an injury or requires medical treatment or the need to alter treatment significantly.