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	04/21/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident #1) reviewed for medication administration, the facility failed to ensure medications that were not administered per physician orders were reported to the physician. The findings include:Resident #1 was admitted to the facility with diagnoses that included anxiety, dermatitis and hypothyroidism. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Mental Interview for Mental Status (BIMS) score of fifteen (15) and was taking antianxiety medication. The Resident Care Plan (RCP) dated 2/17/26 identified Resident #1 had hypothyroidism. Interventions included to give thyroid replacement therapy as ordered, monitor/document/report signs of hypothyroidism, and stress the importance of taking the medication everyday. The RCP further identified Resident #1 had psychotropic medication use related to antianxiety. Interventions included medication as ordered and monitor/document/report adverse reactions. A Psychiatric progress note dated 3/12/16 identified Resident #1 was seen for a mood/behavior assessment in the context of depression and anxiety. Resident #1 identified his/her anxiety was improved. The plan was to continue all psychotropic medications.Review of the March 2026 physician's orders directed Levothyroxine 112 mcg once a day for hypothyroidism, Xanax 1 mg once a day for anxiety and Dupixent 2 ml subcutaneous every 14 days for dermatitis.Review of the Medication Administration Record (MAR) for March 2026 identified the following:1. Resident #1 was administered Levothyroxine 112 mcg on 3/16/26. On 3/17/26 Levothyroxine was not documented as administered with no documentation as to why. On 3/18/26 Levothyroxine was not documented as administered due to not available and on order by LPN #5. Resident #1 was administered Levothyroxine on 3/19/26 (2 daily doses missed). Review of the Pharmacy order form identified Resident #1's Levothyroxine was ordered on 3/14/26 and received by the facility on 3/15/26 (total of thirty tablets).Review of the nursing notes failed to identify the physician was notified that Resident #1 did not receive the prescribed Levothyroxine on 3/17/26 and 3/18/26.2. Resident #1 was administered Dupixent 2 ml on 3/5/26. On 3/19/26 Dupixent was not documented as administered due to not available. Resident #1 was administered Dupixent on 3/21/26 (dose administered 2 days late). Review of the Pharmacy order form identified Resident #1's Dupixent was ordered on 3/20/26 and received in the facility on 3/21/26. Review of the Physician's orders identified the physician was notified Dupixent was not available and renewed the Dupixent order date to 3/20/26. 3. Resident #1 was administered Xanax 1 mg on 3/27/26. On 3/28/26 Xanax was not documented as administered due to not available. Resident #1 was administered Xanax on 3/29/26 (1 daily dose missed).Review of the Pharmacy order form identified Resident #1's Xanax was ordered on 3/28/26 and received in the facility on 3/28/26. Review of the nursing notes failed to identify if the physician was notified that Resident #1 did not receive his/her prescribed Xanax on 3/28/26.Review of APRN #1's progress note dated 3/27/26 identified Resident #1 was seen for follow up of respiratory infection and heart failure. The progress note did not identify she was notified of the medication omissions.Review of the nursing notes for March 2026 failed to identify the physician was notified of the medication omissions. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of APRN #1's progress note dated 4/6/26 identified Resident #1 was seen for follow up of anxiety. Resident #1 continued to intermittently experience episodes of seizure like activity when she missed the morning dose of Xanax. Interview and medical record review with the DNS and Administrator on 4/21/26 at 11:30 AM identified Resident #1's Levothyroxine was ordered on 3/14/26 and delivered to the facility on 3/15/26, therefore there should have been medication available for administration on 3/17/26 and 3/18/26. It was identified that there had been an issue with agency staff documenting medication as not available. The DNS identified the charge nurse was responsible for ensuring medications were ordered prior to not being available for administration. She further identified if a medication was not available, staff were to check the emergency stock (Pyxis), call the pharmacy, document and notify the physician.Interview with APRN #1 on 4/21/26 at 11:59 AM identified if she were notified that Resident #1 did not receive medications, it would have been documented in her progress notes. She identified she should be notified of medication omissions. Interview with LPN #5 on 4/21/26 at 1:17 PM identified on 3/18/26 Levothyroxine was not administered due to not being available. She identified it was not available or administered the previous day either, but was not ordered. She identified she ordered the medication and it was administered on 3/19/26. She identified she did not notify the provider that it was not administered.Interview with LPN #4 on 4/21/25 at 1:42 PM identified on 3/17/26 Levothyroxine was not administered. She identified if a medication was not available she would have checked the system to verify it was ordered, and if not, would have ordered it. She identified she did not notify the provider that it was not administered.The facility policy titled Medication Administration and Documentation directed all medications are to be administered within a two hour time frame (1 hour before or after the medication order time).

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident #1) reviewed for medication administration, the facility failed to ensure medications were administered as ordered. The findings include:Resident #1 was admitted to the facility with diagnoses that included anxiety, dermatitis and hypothyroidism. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Mental Interview for Mental Status (BIMS) score of fifteen (15) and was taking antianxiety medication. The Resident Care Plan (RCP) dated 2/17/26 identified Resident #1 had hypothyroidism. Interventions included to give thyroid replacement therapy as ordered, monitor/document/report signs of hypothyroidism, and stress the importance of taking the medication everyday. The RCP further identified Resident #1 had psychotropic medication use related to antianxiety. Interventions included medication as ordered and monitor/document/report adverse reactions.A Psychiatric progress note dated 3/12/16 identified Resident #1 was seen for a mood/behavior assessment in the context of depression and anxiety. Resident #1 identified his/her anxiety was improved. The plan was to continue all psychotropic medications.Review of the March 2026 physician's orders directed Levothyroxine 112 mcg once a day for hypothyroidism, Xanax 1 mg once a day for anxiety and Dupixent 2 ml subcutaneous every 14 days for dermatitis.Review of the Medication Administration Record (MAR) for March 2026 identified the following:1. Resident #1 was administered Levothyroxine 112 mcg on 3/16/26. On 3/17/26 Levothyroxine was not documented as administered with no documentation as to why. On 3/18/26 Levothyroxine was not documented as administered due to not available and on order by LPN #5. Resident #1 was administered Levothyroxine on 3/19/26 (2 daily doses missed).Review of the Pharmacy order form identified Resident #1's Levothyroxine was ordered on 3/14/26 and received by the facility on 3/15/26 (total of thirty tablets).Review of the nursing notes failed to identify the physician was notified that Resident #1 did not receive the prescribed Levothyroxine on 3/17/26 and 3/18/26.2. Resident #1 was administered Dupixent 2 ml on 3/5/26. On 3/19/26 Dupixent was not documented as administered due to not available. Resident #1 was administered Dupixent on 3/21/26 (dose administered 2 days late).Review of the Pharmacy order form identified Resident #1's Dupixent was ordered on 3/20/26 and received in the facility on 3/21/26.Review of the Physician's orders identified the physician was notified Dupixent was not available and renewed the Dupixent order date to 3/20/26.3. Resident #1 was administered Xanax 1 mg on 3/27/26. On 3/28/26 Xanax was not documented as administered due to not available. Resident #1 was administered Xanax on 3/29/26 (1 daily dose missed).Review of the Pharmacy order form identified Resident #1's Xanax was ordered on 3/28/26 and received in the facility on 3/28/26.Review of the nursing notes failed to identify if the physician was notified that Resident #1 did not receive his/her prescribed Xanax on 3/28/26.Review of APRN #1's progress note dated 3/27/26 identified Resident #1 was seen for follow up of respiratory infection and heart failure. The progress note did not identify she was notified of the medication omissions.Review of the nursing notes for March 2026 failed to identify the physician was notified of the medication omissions. Review of APRN #1's progress note dated 4/6/26 identified Resident #1 was seen for follow up of anxiety. Resident #1 continued to intermittently experience episodes of seizure like activity when she missed the morning dose of Xanax. Interview and medical record review with the DNS and Administrator on 4/21/26 at 11:30 AM identified Resident #1's Levothyroxine was ordered on 3/14/26 and delivered to the facility on 3/15/26, therefore there should have been medication available for administration on 3/17/26 and 3/18/26. It was identified that there had been an issue with agency staff documenting medication as not available. The DNS identified the charge nurse was responsible for ensuring medications were ordered prior to not being available for administration. She further (continued on next page)

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