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	05/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **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 three (3) sampled residents (Resident #1) reviewed for controlled substances, the facility failed to ensure controlled substances were securely stored in separately locked, permanently affixed compartments accessible only to authorized personnel, and failed to maintain accountability and chain of custody for controlled substances during reconciliation and disposal processes, resulting in one (1) bottle of Lorazepam becoming unaccounted for. The findings include:Resident #1 was admitted to the facility with diagnoses that included cerebral atherosclerosis, dementia and a cardiac pacemaker.The Change in Condition Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of one (1), was receiving hospital care while a resident and was taking antidepressant and antianxiety medications.The Resident Care Plan (RCP) dated [DATE] identified Resident #1 used psychotropic medications related to anxiety and depression. Interventions included to administer medications as ordered, monitor for side effects and effectiveness and document adverse reactions.The Hospice Evaluation dated [DATE] identified Resident #1 was being admitted for hospice services, was severely demented, was disoriented with intermittent agitation, anxiety, increased fatigue and lethargy.Physician's orders dated [DATE] to [DATE] directed Lorazepam 0.25 ml orally every four (4) hours as needed for anxiety/restlessness.Physician's orders dated [DATE] to [DATE] directed Lorazepam 0.25 ml orally every four (4) hours as needed for anxiety.The Controlled Substance Disposition Record (CSDR) identified Lorazepam 0.25 ml (30 ml bottle) was received to the facility on [DATE] and returned to the office on [DATE].Physician's orders dated [DATE] to [DATE] directed Lorazepam 0.25 ml orally every six (6) hours for anxiety/restlessness.Physician's orders dated [DATE] to [DATE] directed Lorazepam 0.25 ml orally every six (6) hours for anxiety/restlessness and 0.25 ml orally every two (2) hours as needed for restlessness/agitation.The CSDR identified Lorazepam 0.25 ml (30 ml bottle) was received to the facility on [DATE] and the date returned to the office and dual sign off section was blank.The Nurse Pronouncement Evaluation note dated [DATE] identified on [DATE] at 7:57 PM, Resident #1 was without respirations, blood pressure, pulse and pupil stimuli response. Resident #1 was transferred to the funeral home.The Reportable Event form by the DNS dated [DATE] identified on [DATE] at 10:30 AM while conducting a random controlled substance audit, the DNS identified a Lorazepam discrepancy (Resident #1's Lorazepam). The yellow reconciliation sheet, which was intended to remain with the controlled substance, remained in the controlled substance book and did not match the white sheet. The Drug Enforcement Administration (DEA) was notified and directed the DNS notify the DEA if more controlled substances were identified missing. No further discrepancies were identified. Camera footage review of [DATE] identified the ADNS and LPN #1 removed Resident #1's controlled substances from the unit controlled substance box (two (2) bottles of Lorazepam and one (1) bottle of Morphine) and completed a dual sign off. The footage captured the controlled substances being removed from the unit by the ADNS. The ADNS placed the controlled substances (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into a plastic bag and stored them in a locked controlled substance box in the ADNS office. The ADNS later transferred the controlled substances to the locked controlled substance box in the DNS office. The ADNS refused to provide a statement to the facility. It was identified that there was a breakdown in the chain of custody during the transfer of controlled substances from the ADNS office to the DNS office and the bottle was unaccounted for. The ADNS was suspended pending investigation and terminated.Observation on [DATE] of the DNS office identified a free standing five (5) drawer file cabinet with two (2) locked drawers. Observation of the inside of the file cabinet failed to identify a secondary locked compartment for controlled substances. Observation of the Staff Development office identified a five (5) drawer file cabinet with two (1) locked drawer. Observation of the inside of the file cabinet failed to identify a secondary locked compartment for controlled substances. Neither of the file cabinets were permanently affixed.Interview with the ADNS on [DATE] at 11:55 AM identified on [DATE] LPN #1 asked her to remove Resident #1's controlled substances from the medication cart because he/she expired. She identified she removed three (3) bottles (two bottles of Lorazepam and one bottle of Morphine) and two (2) blister card packs. She was unable to recall how many white controlled substance reconciliation sheets were removed along with the controlled substances. She identified LPN #1 and herself signed off on the controlled substances and she placed the controlled substances in a bag. She identified the normal process was to bring the controlled substances to the DNS office to reconcile and secure. She thought the DNS was out of the building, so she locked the controlled substances in a file cabinet, which was used for employee files, in the Staff Development office. She identified that only she had the key for the file cabinet. She identified the DNS was out sick and did not return until [DATE] (seven days later) and she then reviewed the controlled substances with the DNS. She identified the controlled substances were removed from the bag and the DNS compared the controlled substances and the yellow (DNS copy) and white reconciliation sheets. The ADNS could not identify how many controlled substances or how many reconciliation sheets were present. She denied taking the controlled substances.Interview with the DNS on [DATE] at 12:00 PM identified on [DATE] she conducted a random controlled substance audit. She identified she had one (1) yellow reconciliation sheet for the Lorazepam 30 ml bottle but did not have the white sheet. She identified she should have had the white sheet indicating the controlled substances were reconciled since Resident #1 expired. Her investigation identified on [DATE] the ADNS and LPN #1 dual signed for Resident #1's controlled substance removal from the unit medication cart. Video footage identified a total of five (5) white reconciliation sheets and five (5) controlled substances. The ADNS placed the controlled substances into a plastic bag. The ADNS should have brought the white reconciliation sheets with the corresponding controlled substances directly to the DNS, however, the ADNS stored the controlled substances in a locked file cabinet in the Staff Development office. The ADNS then transferred the controlled substances to the DNS for reconciliation and had four (4) white reconciliation sheets and four (4) corresponding controlled substances. A that time, the DNS was unaware a white reconciliation sheet and a controlled substance were not reconciled. The DNS further identified she was in the building on [DATE] (the day the controlled substances were removed from the unit medication cart), [DATE], [DATE] and [DATE]. She identified the controlled substances should have been brought directly to her for reconciliation after removal from the medication cart.Follow-up interview with the ADNS on [DATE] at 1:10 PM identified the DNS was in the building on [DATE], [DATE] and [DATE] and the ADNS was present for morning report those days along with the DNS. The ADNS could not remember why she waited seven days to reconcile the controlled substances with the DNS and identified she should have given the controlled substances directly to the DNS.Review of the Controlled Substance Handling policy directed that all controlled drugs will be subject to special receipt, handling, storage, disposal and record keeping. All controlled drugs shall be stored in a two (2) door double locked cabinet with two (2) separate keys designed for that purpose, separate from all other drugs. Discontinued controlled drugs are returned to the nursing office after count is verified. The drugs are (continued on next page)

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