



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection

103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

June 29, 2010

James Beeler, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 25, 2010**. Please post this document in a prominent place in your facility.

We will 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,

A handwritten signature in cursive script that reads "Suzanne E. Leavitt RN, MS".

Suzanne Leavitt, RN, MS
Assistant Director

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2010
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NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite complaint investigation was initiated on 4/26/10 by the Division of Licensing and Protection. The investigation was completed on 5/25/10. The following regulatory violations were identified.</p> <p>F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan to address the area of potential urinary incontinence, toileting assistance, and history of urinary tract infections for one resident (Resident #1). Findings include:</p>	F 000	<p>F 279</p> <p>Resident # 1 was discharged. No residents were effected by this alleged deficient practice.</p> <p>MDS' of all residents with the potential for urinary incontinence, requiring toileting assistance, and history of urinary tract infection will be reviewed. Care plans will be developed as necessary.</p> <p>MDS' of those residents due for care planning will be reviewed weekly X 90 days. Care plan will be implemented and/or changed as necessary.</p> <p>Random audits will be done weekly x 90 days.</p> <p>The results of all audits will be reported to the facility QA committee for review x 90 days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date June 25, 2010</p> <p><i>PC August 6-28-10</i></p>	<p>RECEIVED</p> <p>Division of JUN 16 10 Licensing and Protection</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 6/15/2010
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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.

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F 279	Continued From page 1 Per record review, Resident #1 was coded in the Minimum Data Set (MDS) Annual Assessment of 7/19/09 as needing one person physical assistance with toileting, is on a scheduled toileting plan, and had a urinary tract infection in the last 30 days. The resident was also noted in Nurse Progress Notes documentation to have had an actual urinary tract infection (UTI) in December 2009 that was treated with antibiotics. Per review of the care plan dated 1/11/10, the only mention of any of these concerns was under a care plan for Activities of Daily Living that stated "Provide supervision for toileting". The care plan did not include interventions to describe the assistance needed for toileting, monitoring for signs of urinary tract infections, or a toileting schedule plan to promote urinary continence. Per interview on 4/27/10 at 2:45 PM, the Assistant Director of Nursing confirmed that a plan of care for these areas of concern had not been developed for this resident.	F 279	/	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide services that meet professional standards of practice for one resident (Resident #1). Findings include: 1. Per record review on 4/26/10 and 4/27/10, Resident #1 had a history of Urinary Tract Infections, one in July 2009 according to the MDS, and again in December 2009 documented	F 281		

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F 281	<p>Continued From page 2</p> <p>in Nurse Progress Notes. On March 16, 2010 the nurse documented at 10:30 AM that the MD was called when the resident was incontinent of stool and refusing care to clean him/her up. At that time, the Resident's temperature was 100.9 degrees Fahrenheit (F), and the only medication h/she would accept was Acetaminophen 1000 mg. There were multiple attempts that day to obtain a urine sample to test for a UTI, however the resident would remove the collection device from the toilet and was continuing to resist care including medications. There was no evidence that an MD order was obtained for the Urinalysis. The nurse documented at 3:00 PM on 3/16/10 that the Resident's temperature was 99.0 F, and staff were still unsuccessful in their attempts to collect a urine sample. Per review of the Nurse Progress Notes for the next twelve days, there was no mention of further attempts to collect a urine specimen, or any documentation indicating that they were not going to pursue the testing. On March 28, 2010, the Resident's daughter came to the facility after being out of town since for over a week, found out that a urinalysis had not been done, and insisted the doctor be contacted to obtain an order for the test. The physician gave a telephone order on March 28 at 10:00 PM to "obtain urine for UA" and the staff was able to collect the urine on March 29 at 2:00 PM. According to the Laboratory Dept. report dated 3/31/10, Resident #1 tested positive for a UTI. Per interview on 4/27/10 at 2:15 PM, the nurse who cared for her during this time period stated that although Resident #1 had a fever on 3/16/10, the fever resolved by the following day, and she was not exhibiting other signs of a UTI that met the criteria for testing so the urinalysis was not pursued, and that she had not documented the reason in the Nurse Progress Notes.</p>	F 281	<p>F 281</p> <p>Resident # 1 was discharged. No residents were effected by this alleged practice.</p> <p>The nurses will identify any resident who, in the judgment of the nurse, requires a "dip" of urine for possible infection. The results of the nurses attempt to secure the urine will be documented in the nurses notes.</p> <p>Nurses will be educated regarding documentation.</p> <p>Residents requiring a "dip" of urine will be reviewed at the concurrent report and at shift report.</p> <p>Random audits of residents with a "dip" urine will be done weekly x 90 days. The audits will be reviewed at the facility QA meeting x 90 days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date June 25, 2010</p> <p><i>POC urgent 6-28-10</i></p>	
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