

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 23, 2015

Ms. Heather Filonow, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641-5421

Dear Ms. Filonow:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 14, 2015**. Please post this document in a prominent place in your facility.

We may 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,



Pamela M. Cota, RN
Licensing Chief



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

NOV 18 2015

PRINTED: 10/26/2015
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 10/14/2015
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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

INITIAL COMMENTS

The Division of Licensing and Protection conducted an unannounced onsite recertification survey 10/12/15 - 10/14/15. Regulatory violations were cited as a result.

F 000

F 280
SS=D

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to revise the care plan for 3 of 16 applicable residents to reflect their current needs for care and services (Resident #48, 27 and 13). Findings include:

1. The facility did not revise the care plan for

F280

How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

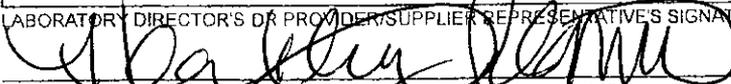
Residents #48, #27, and #13 care plans have been updated to reflect their current status and their individualized care needs.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents have the potential to be affected by the alleged deficient practice.

What measures will be put on place to ensure that the deficient practice will not occur?

Nursing Staff have been educated on resident plans of care and the need for the care plans to be updated for residents to reflect changes as they occur.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 11/10/15
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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 280	<p>Continued From page 1</p> <p>Resident #48 regarding a mobility device, footrest padding, and toileting regime. Per observation during three days of survey, the resident was in a tall back wheel chair and the foot rests were not padded. Per review of the recent assessment [dated 09/10/15] notes that the resident needs extensive assistance with transfers and activities of daily living [mobility, toileting and dressing]. The current care plan dated 08/26/15 notes the following; ...tilt in space chair with bilateral leg rests, padded footbox, and headrest; assist of 2 for toileting and incontinence care before and after meals, with AM and HS [night] care and PRN [as needed]; Provide bowel regimen per facility protocol. The facility's Bowel regime states "...no BM results by day 4 after all interventions then MD will be consulted."</p> <p>Per interview on 10/13/15 at 2:30 PM, the physical therapist assistant acknowledged that the wheel chair the resident was currently seated in was not a tilt in space nor was the foot rest padded and stated that "it got changed a few months ago". During interview shortly thereafter, the Unit Manager (UM) stated that there were changes to the resident's wheel chair from the tilt in space and padded foot rest and confirmed that the care plan was not revised to current interventions.</p> <p>Additionally, during review of the resident's chart, the bowel report dated 09/30 -10/13/15, shows there was no bowel movement noted 10/05 through 10/10/15 (5 days) but there is no evidence that the physician was notified, on day 4 or day 5, per bowel regime protocol. Per interview with Director of Nursing (DON) and the Regional Clinical Manager at 3:36 PM on 10/13/15 noted that "the Bowel Protocol in the care plan is not applicable to this resident as [resident's] pattern is that [resident] doesn't go for</p>	F 280	<p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</u> DNS or designee or will conduct random weekly audits to ensure care plan reflects current needs. Weekly times 12. The results of the audits will be reported to the monthly QAPI committee for 3 months at which time the QAPI committee will determine further frequency of the audits. F280 11/11/15</p> <p><i>F280 POC accepted 11/11/15 RTremblay RN/PMC</i></p>

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F 280	<p>Continued From page 2</p> <p>3-5 days". They confirmed that the care plan should be revised to reflect the current and individualized status of this resident.</p> <p>2. Per record review on 10/13/15, the care plan for Resident # 27 was not revised to reflect his/her current medical needs and interventions related to medication and safety monitoring. Per record review, Resident #27 was readmitted to the facility on 5/22/15 following a hospitalization. A care plan was initiated on 5/29/15 for "potential for bleeding related to the use of an anti-platelet medication (Cilostazol)" and included interventions for monitoring for bruising, labs as ordered and education related to potential side effects of the medication. On 6/1/15, Cilostazol was discontinued. On 10/13/15 at approximately 3 PM, the Unit Manger (UM) confirmed that Resident #27's care plan had not been revised on 6/1/15 (at the time Cilostazol was discontinued) or on the resident's subsequent readmissions to the facility. The UM reported that on 6/1/15 when the staff nurse took a telephone order from the physician to discontinue the Cilostazol, the nurse should have entered the information on the "care plan update clipboard" to alert the UM to revise the care plan as otherwise, the UM would not be aware of the change in medication and the need for the care plan to be revised. The UM reported that in this instance, the lack of staff following an update procedure led to the care plan not being revised.</p> <p>3. The care plan for Resident #13, related to the use of a Foley catheter, was not revised to reflect a plan to restore as much bladder function as possible and to potentially discontinue a catheter that was no longer medically justified for a</p>	F 280		
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F 280	Continued From page 3 resident with an expressed wish to return home. Per record review, Resident #13 had a urinary catheter in place for over a year. Physician orders from 4/22/15 indicated that the catheter was currently in place due to a history of intermittent skin breakdown and urine associated dermatitis of the buttocks. Per 10/14/15 medical record review and staff and Unit Manager (UM) interviews, Resident #13's skin had been clear of breakdown since the order change in April. The UM confirmed that there was no current medical justification for a urinary catheter other than the resident had refused to have the catheter removed in the past. The UM confirmed that since the resident's skin issues had resolved, there is no evidence that the resident's care plan had been revised to include the development of educational strategies, approaches and interventions to work on restoring Resident #13's bladder function to its highest function and for the possible removal of the catheter. The care plan also did not address the resident's past refusals to have the catheter removed and educational strategies and interventions to ensure that the resident is aware of the risks associated with long term catheter use and the potential benefits of a bladder retraining program to help the resident attain or maintain his/her highest practicable level of well-being. (Refer to 315)	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	<p>Continued From page 4</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 applicable resident with a urinary catheter had a valid medical justification for the catheter's use, failed to ensure that staff had provided treatment and services to restore or improve normal bladder function to the extent possible and failed to ensure that education and services were provided to attempt to have the catheter discontinued as soon as clinically warranted (Resident #13). Findings include:</p> <p>Per record review and interview with the Nurse Unit Manager (UM) on 10/14/15, Resident #13 had a urinary catheter in place for over a year. Physician orders from 4/22/15 indicated that the catheter was currently in place due to a history of intermittent skin breakdown and urine associated dermatitis of the buttocks. On 10/13/15 at 4:05 PM, a LNA (Licensed Nursing Assistant) who had regularly provided care to the resident for the past 4 months reported that the resident's peri-area and buttocks had no skin breakdown or significant rashes during those 4 months. Per review of weekly skin assessments and nursing notes, there was no documentation of buttock area skin breakdown and the UM confirmed that there had been no skin breakdown since the order change was made in April.</p> <p>Per interview on 10/14/15, at 9:45 AM, the UM</p>	F 315	<p><u>F315</u></p> <p><u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #13 has been educated regarding the risks associated with catheter use. The facility is currently developing a plan to attempt removal of the foley catheter.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> Residents with foley catheters have the potential to be affected by the alleged deficient practice.</p> <p><u>What measures will be put in place to ensure that the deficient practice will not occur?</u> In addition to resident education, staff will be educated regarding appropriate uses for foley catheters and the requirement to provide resident education as it relates to risks of catheter use.</p>	

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F 315	Continued From page 5 confirmed that there was no medical justification for the Foley catheter. S/he reported that in the past, staff were of the mindset that [the resident] was "refusing" to have the catheter removed so we "didn't push it." The UM confirmed that since the resident's skin issues had resolved, there is no evidence that the resident had been provided with education or interventions to work on restoring Resident #13's bladder function to its highest function and for the possible removal of the catheter. Additionally, the UM confirmed that the resident's care plan was not revised to address the resident's past refusals to have the catheter removed and educational strategies and interventions to ensure that the resident was aware of the risks associated with long term catheter use and the potential benefits of a bladder retraining program to help the resident attain or maintain his/her highest practicable level of well-being. (Refer to F280)	F 315	<u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</u> Random audits will be conducted as needed for residents with foley catheters to ensure documented education and appropriate use of catheters. The results of the audits will be reported to the monthly QAPI committee for 3 months at which time the QAPI committee will determine further frequency of the audits.	11/11/15	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to ensure that the residents' environment remains as free of	F 323	<u>F323</u> <u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> No residents were negatively affected by this alleged deficient practice. The water temperature was adjusted immediately upon identification.		

F315 PCC accepted 11/11/15 RTrembajen/jpmc

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F 323 : Continued From page 6
accident hazards as possible. For all 26 resident rooms on one of the two units in the facility, the findings include the following:

During Stage 1 of the annual survey that began on 10/12/15, 3 State Surveyors observed numerous resident bathrooms on Wing 1 with water temperatures above 120 degrees F (Fahrenheit).

Per tour with the facility Maintenance Director on 10/12/15 at 4:15 PM, 26 Resident bathrooms on Wing 1 had water temperatures measuring from 121.4 degrees F to 126 degrees F. Many of the rooms are occupied by residents who are able to utilize the bathroom sinks independently and others wander independently throughout the facility. Both the Unit Manager and the Director of Maintenance confirm the water temperatures are at dangerous levels and that numerous residents are placed at risk for injury.

F 431 : 483.60(b), (d), (e) DRUG RECORDS, SS=D LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when

F 323 : How will the facility identify other residents having the potential to be affected by the same deficient practice?
Residents residing in the facility have the potential to be affected by the alleged deficient practice.

What measures will be put on place to ensure that the deficient practice will not occur?

Facility Executive Director and Maintenance Director have reviewed and are aware of the regulatory requirements as it relates to safe water temperatures.

How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?

Twice daily water temperature audits will be conducted by the Maintenance Director or designee to ensure safe temperatures.

The results of the water temperature audits will be reported to the monthly QAPI committee for 3 months at which time the QAPI committee will determine further frequency of the audits.

F323

11/11/15

F323 POX accepted 11/19/15 Rtrvmbly R/PML

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F 431	<p>Continued From page 7 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all medications were properly stored and labeled or discarded when they reached their expiration date in accordance with accepted professional principles for 1 of 4 medication carts. Findings include:</p> <p>Per observation on 10/13/15 at 4:15 PM, the medication cart for the Wing 1 short hall contained 2 Lantus Solostar pens labeled with Resident #81's name (Lantus Solostar = an injectable insulin). One of the Solostar pens was in-use and labeled with the day it was opened (10/12/15) and the discard date (11/8/15). The second Solostar pen was unopened and not dated when it was placed on the medication cart. According to the manufacturer's package insert,</p>	F 431	<p>F431</p> <p><u>How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> No residents were negatively affected by this alleged deficient practice.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> Residents requiring medication have the potential to be affected by the alleged deficient practice.</p> <p><u>What measures will be put on place to ensure that the deficient practice will not occur?</u> Education to be provided to licensed nurses regarding the requirements for labeling and storage of drugs.</p> <p><u>How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?</u> Random weekly audits will be conducted by the DNS or designee to monitor effectiveness of the plan. The results of the audits will be reported to the monthly QAPI committee for 3 months at which time the QAPI committee will determine further frequency of the audits.</p> <p>F431 11/11/15</p>

F431 POC accepted 11/19/15 RTremblay RN/Pine

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F 431	<p>Continued From page 8</p> <p>Lantus insulin that is not in-use (unopened) should be refrigerated (at 36-46 degrees F); if the insulin is not refrigerated it can be stored for up to 28 days and then should be discarded. The staff nurse administering medications from the cart confirmed the above observations and that the second Solostar pen should have been refrigerated as Resident #81 had a newly opened insulin pen that was in-use and the second pen was not needed.</p> <p>Also on the cart was a bottle of Robafen Expectorant (cough syrup) with an expiration date of 9/2015. The bottle was labeled as opened on 10/12/15 (12 days past the expiration date). The medication administration nurse confirmed that the medication was opened and labeled in-use after its expiration date and should have been discarded.</p>	F 431		
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