

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

April 13, 2015

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

Dear Ms. Campbell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 17, 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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 02/17/2015
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROWAN COURT HEALTH & REHAB

378 PROSPECT STREET
BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

An unannounced on-site complaint investigation and a self-report investigation was conducted by the Division of Licensing and Protection on 2/17/15. The findings include the following:

F 280 483.20(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 medical record review, the facility failed to revise a care plan for 1 of 5 sampled residents after an alleged report of physical and mental abuse by Resident #1 who is the alleged perpetrator. The findings include the following:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tim Campbell TITLE: Executive Director (X6) DATE: 4/7/2015

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 60 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 Continued From page 1

Per medical record review, Resident #1 was admitted on 8/4/14 with diagnoses to include Alzheimer's Disease, Chronic Kidney Disease, severe Depression, Failure to Thrive, recurrent Urinary Tract Infections and Hypertension.

Per medical record review on 2/17/15 at approximately 10 AM, incident and progress notes for Resident #4 (victim), identifies that the resident had a traumatic Foley Catheter removed by Resident #1 (alleged perpetrator).

Per medical record review for Resident #1, there is no evidence documenting the traumatic Foley removal as identified on the an incident report and progress note for Resident #4, dated 12/22/14.

Per interview with the Unit Manager (UM) on 2/17/15 at 2 PM, confirmation is made that there is no progress note or care plan revision/update for Resident #1 regarding the incident between Resident #1 and Resident #4 that occurred on 12/22/14.

F 323 483.25(h) FREE OF ACCIDENT
 SS=G 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

F 280

F 323

Preparation and or execution of this plan of correction does not constitute the providers admission of/or agreement with the alleged violations or conclusion set fourth in this statement of deficiencies. This plan of correction is prepared and/or executed as required by State and Federal Law.

F 280.483.20(d)(3).483.10(k)(2)

1. Resident #1 and Resident #4 care plans have been updated to reflect the accident.
2. Education has been provided to licensed staff on the requirement for updating resident care plans.
3. Random audits are being conducted 3 times weekly by the DON or designee to monitor the effectiveness of the Plan. The results of the audits are being reported to the QAA committees for (3) three months. The QAA committee will determine the continuance and frequency of audits.
4. DNS and ED considered the incident to be an accident. Resident #4 insisted upon being transferred to his original room and he was transferred on 12/31/14. Patient relates he feels safe in his room.
5. Corrective action was completed on 3/16/15.

F280 ROC accepted 4/13/15 Amc...

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F 323 Continued From page 2
 by:
 Based on staff interview and medical record review the facility failed to ensure that 1 of 5 sampled residents, (Resident #4) was free from accidents and that each resident receives adequate supervision to prevent accidents. The findings include the following:

Per medical record review, progress notes and incident report dated 12/22/14 evidence written documentation by the Licensed Practical Nurse (LPN) identifying that at approximately 1530 (3:30 PM), staff heard Resident #4 yelling "No...No...Oh God No". Resident #1 "was observed coming out of Resident #4's room with a catheter that still had a drainage bag attached and an inflated balloon on the catheter, with bright red drainage noted to end of catheter in [his/her] right hand". LPN observed and documented that Resident #4 was "visibly distraught, tears streaming down cheeks and sobbing hysterically, continuously rubbing head and face with hands and repeatedly stating don't let her hear me again, I am too scared here. please don't leave me, I don't want to be here anymore. Oh God, keep that woman away from me." LPN cleansed the affected area, applied pressure to stop bleeding and notified physician, administrator, director of nurses and responsible party. Resident was transferred to another Unit within the facility. Per review of Resident #4's interdisciplinary Care Plan, page 3 of 18 identifies a focus of "Foley Catheter removed traumatically by another resident who suffers from dementia. Dated 12/22/14 by Unit Manager" (JM).

Per care plan review on 2/17/15, Resident #1 has a care plan focus dated 12/8/14, created by the JM, identifying that the resident has made

F 323

F323.483.25(h)

- Residents with a history of intrusive behavior will be provided adequate supervision as per plan of care.
- Education was been provided to the staff regarding adequate supervision for intrusive behaviors as per resident care plan.
- Random audits are being conducted 3 times weekly by the DON or designee. To monitor the effectiveness of the plan, results of the audits will continue to be reported to the QAA committees for (3) three months. QAA committee will determine the continuance and frequency of audits.
- DNS and ED considered the incident to be an accident. Resident #4 stated, "she thought my catheter was a pair of shoes that belonged to her and she took my catheter right out." On 12/31/14 he insisted upon being transferred to his original room and he was. Patient relates he feels safe in his room.
- Corrective action was completed by 3/16/15.

F323 POC accepted 4/13/15 Pmca/Pm

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

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F 323 Continued From page 3

physical contact with another resident. Interventions include that the nursing staff and social services are to be under mindful observation for signs and symptoms of aggressive behaviors and staff will be mindful of Resident #1's intrusive behaviors and redirect his/her attention elsewhere if invading another residents personal space.

Per review of Behavior Interventions on 2/17/15, identifies recent interactions with other residents. The document evidences that Resident #1 wanders and enters others personal space. This document was reviewed with the Unit Manger and confirms the incident dated 12/22/14.

Per interview with the Director of Nurses (DNS) on 2/17/15 at 8:45 AM, confirms that the incident was reviewed with the Administrator. The result of the traumatic removal of the Foley Catheter caused pain and mental anguish to Resident #4, as identified in the progress notes and continued through 1/21/15.

Per conversation with the DNS on 2/17/15, confirmation is made that the resident's care plan identifies that Resident #1 is a known wanderer as documented on both Care Plan and Minimum Data Set Assessment.

F 323