

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 19, 2015

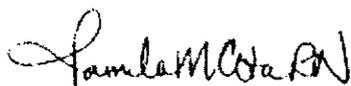
Ms. Heather Filonow, Administrator  
Rowan Court Health & Rehab  
378 Prospect Street  
Barre, VT 05641-5421

Dear Ms. Filonow:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 7, 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



NO PLAN OF CORRECTION

IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

475037

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

C

10/07/2015

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 investigation was conducted on 10/06/15 - 10/07/15 by the Division of Licensing and Protection to investigate self-reported incidents and a complaint. The following are regulatory findings.

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)  
SS=0 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

F 225

F225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

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

Resident #1 has remained in the facility without any negative impact.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

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 deficient practice.

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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

Facility staff have been re-educated on the immediate reporting of any abuse allegation.

The results of all investigations must be reported to the administrator or his designated

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

*Heather L. Lane*

Executive Director

11/4/2015

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution provides sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days after 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.

PLAN OF CORRECTION	IDENTIFICATION NUMBER:  475037	A. BUILDING _____  B. WING _____	COMPLETED  C 10/07/2015
F PROVIDER OR SUPPLIER  DWAN COURT HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 225 Continued From page 1  
representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:  
Based on staff interviews and medical record review, the facility failed to report immediately to the administrator of the facility and to other officials in accordance with State law an allegation of mistreatment and/or abuse for 1 of 5 residents in the sample. (Resident #1) Findings include:

- The facility made a late report of potential mistreatment four days after an alleged incident. Per review of a report dated 07/29/15 to the State agency, an allegation of mistreatment took place on 07/25/15. A written statement on 07/25/15, states LNA #1 (licensed nursing assistant) instructed a new hire, LNA #2 to bring in juice that, knowingly, Resident #1 didn't like. The statement went on to say LNA #1 poured the juice and handed two cups to LNA #2. When LNA #2 went into the room, the Resident started yelling at LNA #2 that (resident) "didn't like that type of juice and should have known that". Then LNA #1 and the dietary staff started to laugh out in the hall.

Per a social worker interview on 07/29/15 with the resident states "she (resident) was furious, they know I don't like it and it makes me angry". A written statement made by the dietary staff on 07/29/15 noted "... in [our] conversation we told [LNA #2] that the new LNA's learn the hard way

F 225 How will the facility monitor its corrective actions to ensure that the deficient practice will not reoccur?  
There will be random interviews of the facility staff conducted to ascertain staff understanding of immediate reporting of allegations of abuse.  
There will be random audits three times a week for three months to monitor for the effectiveness of the plan.

Results will be reported through the QAPI process. The QA committee will determine continued duration of interviews after three months.

The Executive Director or designee is responsible for this process

11/07/15

Fac POC accepted 11/19/15 Semmons RN/PMC

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(A1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

476037

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

DATE OF SURVEY  
COMPLETED

C

10/07/2015

NAME OF PROVIDER OR SUPPLIER

DOWAN COURT HEALTH & REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

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

F 225 Continued From page 2  
that [Resident] doesn't like [certain juice] if they  
put it on [the] tray without knowing".

F 225

Additionally, during interview on 10/08/15 at 4:40  
PM the Administrator acknowledged that LNA #1  
continued to work after this incident up until  
termination of employment on 07/29/16. The  
administrator confirmed that staff did not  
immediately report to a supervisor, as expected,  
and was reported late to the State Agency.

F 329 483.25(i) DRUG REGIMEN IS FREE FROM  
SS=D UNNECESSARY DRUGS

F 329

Each resident's drug regimen must be free from  
unnecessary drugs. An unnecessary drug is any  
drug when used in excessive dose (including  
duplicate therapy); or for excessive duration; or  
without adequate monitoring; or without adequate  
indications for its use; or in the presence of  
adverse consequences which indicate the dose  
should be reduced or discontinued; or any  
combinations of the reasons above.

Based on a comprehensive assessment of a  
resident, the facility must ensure that residents  
who have not used antipsychotic drugs are not  
given these drugs unless antipsychotic drug  
therapy is necessary to treat a specific condition  
as diagnosed and documented in the clinical  
record; and residents who use antipsychotic  
drugs receive gradual dose reductions, and  
behavioral interventions, unless clinically  
contraindicated, in an effort to discontinue these  
drugs.

F329

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

Resident #1's MD orders have been  
reviewed.

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

Residents with orders for antipsychotic  
medications have the potential to be  
affected.

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475037	(A2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X7) DATE RECEIVED COMPLETED  C 10/07/2015
NAME OF PROVIDER OR SUPPLIER  OWAN COURT HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 329 Continued From page 3

This REQUIREMENT is not met as evidenced by:  
Based on record review and interview the facility failed to assure that 1 of 3 applicable residents reviewed for use of psychotropic medications was receiving adequate monitoring, dosing and non-pharmacological interventions. (Resident #2) Finding includes:

1. Resident #2 has a Diagnosis of dementia with behavioral disturbance, for which Seroquel 25 mg, an anti-psychotic medication, was given as needed (PRN) without adequate monitoring and/or non-pharmacological interventions. In addition, there is no supporting documentation of a physician order for a scheduled dose of Seroquel that was canceled. The care plan for psychotropic medications dated 02/25/15 directs staff to implement non-pharmacologic and other interventions as follows: to show the resident the photo book, reapproach and allow time, monitor behaviors, offer approaches for behavior intervention prior to the use of PRN as identified on behavior sheet, that staff are aware to back away during increased physical aggression, maintain safe distance during periods of increased agitation or aggression, will have 1-1 supervision until signs and symptoms have passed, when aggressive re-approach, offer food/beverage and maintain the safety of all, asses for pain and offer PRN meds per MD orders.

Per review of the MAR (medication administration record), behavior sheet and progress notes, the resident was medicated 6 out of 18 times during the month of July 2016 with PRN Seroquel 25mg that had neither evidence of non-pharmacological

F 329

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

Residents have had their medication regime reviewed for antipsychotics and the necessary documentation regarding alternative non-pharmacological measures before administering the antipsychotic.

Nursing staff has been re-educated on the giving of prn psychotropic medications and the parameters and documentation that is needed.

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

An audit will be conducted for the adherence to administration of prn psychotropic and documentation of non-pharmacologic interventions. There will be random audits three times a week for 2 weeks. Weekly audits times 4 then monthly audits times 2. Results will be reported through the QAPI process with interventions as appropriate.

The DNS or designee is responsible for this process

F329 PDC accepted 11/19/15 SEMMONS RN/PMC

11/07/15

PLAN OF CORRECTION	IDENTIFICATION NUMBER:  475037	(X5) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X7) STATE COMPLETED  C 10/07/2015
NAME OF PROVIDER OR SUPPLIER  LOWAN COURT HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05644	

(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)	(X6) COMPLETION DATE
F 329	Continued From page 4 interventions that were attempted prior to medication administration nor specific targeted behaviors. For the month of August 2015, 3 out of 11 PRN Seroquel 25mg that were administered, also did not have non-pharmacological interventions that were attempted prior to medication administration or specific behaviors. Per interview at 2:03 PM on 10/06/15 the Director of Nursing (DON) confirmed that documentation in the resident's medical record showed no evidence that non-pharmacological interventions were attempted and/or the specific behavior for the use of PRN Seroquel.  In addition, there were two signed orders, but only one was noted on the MAR. Both verbal orders (08/03/15) were signed by the physician on 08/11/15. The first order states: Seroquel 25 mg every day and 25mg half tab (12.5) at h.s. [bedtime] and the second order states: Seroquel 25 mg b.i.d. (twice a day). Only the Seroquel 25 mg b.i.d was on the MAR. A progress note dated 08/08/15 states "give Seroquel 25mg qd [daily], MD considering increasing PM dose but has not done so at this time, wants report in one week of changes..." The Unit Manager (UM) stated that the physician was contacted in the morning of 08/03/15 and gave a verbal order for the first Seroquel order but after a team meeting the physician was contacted in the early afternoon for the request of the second Seroquel order for the increase to 25mg b.i.d. The UM stated that the physician changed his mind, however, confirmed there is no documentation of a progress note or a cancellation for the first Seroquel order.	F 329		