

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

103 South Main Street, Ladd Hall

Waterbury VT 05671-2306

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Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

January 6, 2012

Mr. James Beeler, Administrator  
Rowan Court Health & Rehab  
378 Prospect Street  
Barre, VT 05641-5421

Dear Mr. Beeler:

**INITIAL NOTICE OF IMMEDIATE JEOPARDY**

On **January 5, 2012** a complaint survey was completed at your facility by the Vermont Division of Licensing and Protection to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with the participation requirements, and the conditions in your facility constituted immediate jeopardy to resident health or safety and constituted substandard quality of care.

**Immediate Jeopardy with Substandard Quality of Care**

The most serious deficiencies identified in your facility constitute isolated deficient practices at **42 CFR Part 483.20(k)(3) - Professional Standards of Practice (F281)**; **42 CFR Part 483.25(l) - Unnecessary Drugs (F520)**; **42 CFR Part 483.25(m)(2) - Medication Errors (F333)**; and **42 CFR Part 483.75(l) - Clinical Records (F514)**.

During the investigation from January 4 - January 5, 2012, staff interviews and record review revealed that a series of significant medication errors occurred, effecting one applicable resident (Resident #1). On December 31, 2011, Resident #1 was the recipient of a significant medication error where the resident received 20 milligrams (mg) of Ambien (a sedative/hypnotic medication used for insomnia) when the nurse was intending to administer 2 mg of Ativan (an anti-anxiety medication). There is no evidence of this significant medication error in the Resident's medical record nor evidence of ongoing assessments during the following shifts in regards to the potential effects of the medication error. Prior to the medication error, per review of nurses' notes, Resident #1 was admitted on 12/27/11 for end of life care as alert, oriented, and able to make his/her needs known. From 12/28/11 through the evening of 12/31/11, the resident was noted to be ambulating with a walker independently and was able to ask staff when s/he needed medications to treat symptoms.

The following telephone orders were transcribed by Nurse #1 on 12/31/11 at 10:30 PM but not countersigned by the prescribing practitioner: 2 mg Ativan every 4 hours while awake, ABHR cream 1 mg topical every 2 hours scheduled, and 4 mg Morphine subcutaneously every 2 hours throughout the night. ABHR cream is a topical cream that contains Ativan (anti-anxiety), Benadryl (anti-histamine), Haldol (anti-psychotic) and Reglan (used for treatment of nausea). Side effects for all of the included medications include drowsiness/sedation. Prior to this telephone order, the ABHR cream and the Morphine were PRN (as needed) medications to treat complaints of anxiety/agitation and pain, respectively. Throughout the night of 12/31/11 - 1/1/12 and through the day shift on 1/1/12, the Morphine and ABHR cream were given by 2 different nurses every 2 hours per the above mentioned telephone orders received on 12/31/11. Per review of nurses' notes, Resident #1 slept all night from 12/31/11 to 1/1/12, and a note for the day shift of 1/1/12 states the resident slept throughout the shift, and that the nurse continued to administer the ABHR cream and 4 mg Morphine every 2 hours as ordered. The nurses' note on 1/1/12 also states that the resident was having periods of apnea (temporary cessation of breathing) as early as 9:30 AM, yet staff continued to give the sedating medications in the absence of signs of pain or anxiety.

Per interviews on 1/4/12 and 1/5/12 with the Nurse Practitioner (NP) noted on the telephone order as giving the order, s/he stated that s/he did not give the above orders to Nurse #1, but gave different orders to Nurse #2 who was not in the facility at the time. The NP verified that s/he did not order Ativan 2 mg to be given every 4 hours while awake, but rather ordered a one time dose of Ativan to be given for increased anxiety that the resident was exhibiting prior to the significant medication error involving Ambien. The NP also verified that she did not order the ABHR cream to be given every 2 hours scheduled, and also verified that the scheduled Morphine was to be given only throughout the night shift. Due to this information, the 7 doses of ABHR cream given in the absence of signs or complaints of anxiety/agitation from 2:00 AM to 2:00 PM on 1/1/12 were significant medication errors, and the 3 doses of Morphine given in the absence of signs or complaints of pain from 9:30 AM to 1:30 PM were also significant medication errors. There was no order present in the medical record to continue the scheduled Morphine administration into the daytime hours. The resident passed away around 3:30 PM on 1/1/12.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

### **Recommended Enforcement**

**Termination:** As a result of the survey findings, the Vermont Division of Licensing and Protection is recommending to the CMS Regional Office termination of your Provider Agreement effective **January 27, 2012**, giving the facility **22 days** to remove the immediate jeopardy.

**CMP:** A per instance civil money penalty of not less than **\$4500.00** is recommended for the Immediate Jeopardy. A change in remedies may be recommended upon the completion of the extended survey and you will receive notice under a separate cover.

## Allegation of Compliance

In order to avoid termination you must **remove the Immediate Jeopardy and submit to this office a letter of credible allegation of compliance.** You need not submit a full plan of correction until you have received a complete CMS Form 2567 from this office.

Your credible letter of compliance must be submitted by **January 13, 2012.** Failure to submit a credible letter of compliance by **January 13, 2012** will result in the imposition of termination of your Provider Agreement by **January 27, 2012.**

**Your credible letter of compliance must contain the following:**

- **How the jeopardy is removed (in sufficient detail the steps taken to remove the jeopardy).**
- **When the jeopardy was removed.**

If you have questions, please contact me at (802) 871-3317.

Sincerely,



Frances L. Keeler, RN, MSN, DBA  
Director

CC: CMS RO  
State Medicaid Agency