

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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 14, 2014

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 **March 19, 2014**. 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

PC:jl

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

PRINTED: 03/17/2014
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 _____	RECEIVED Division of APR 11 11 Licensing and Protection	(X3) DATE SURVEY COMPLETED 03/19/2014
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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	F 000		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to promote care for 8 out of 20 residents in a manner during meal experiences that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (Residents #15, #33, #40, #42, #53, #54, #55 & #84) Findings include:</p> <p>1. During observation of two dining experiences Residents were not assisted with their meals and/or drinks in a timely manner as follows:</p> <p>A) During the Noon meal on 03/17/14, it was observed that there were approximately 11 residents in the sunroom awaiting their noon meal. Residents #33, & #53 were observed to be sitting in the sunroom on Unit 2 at 12:05 PM awaiting their noon meal.</p> <p>During the course of the observation Resident # 53 waited from 12:05 PM until 1:00 PM to be served and assisted with their noon meal. Resident # 33 waited from 12:05 PM until 12:38</p>	F 241	<p>Preparation and/or execution of this plan of correction does not constitute the providers admission of/or agreement with the alleged violations or conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed as required by state and federal law.</p> <p>F 241 483.15(a)</p> <p>Resident's #15, 33, 40, 42, 53, 54, 55, and 84 had no negative effect as a result of this alleged deficient practice.</p> <p>Residents requiring assistance with meals have the potential to be affected by the alleged deficient practice.</p> <p>Education will be provided to staff that assist residents with meals regarding dignity and respect of residents during meal service.</p> <p>The facility has revised the dining process to better accommodate individual needs during meal times and education was provided to staff.</p> <p>Audits will be done at a minimum of 3X weekly by the DON or designee to monitor the effectiveness of the dining plan.</p> <p><i>POC - F241 accepted 4/14/14 Susan J. Emmons RN</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kim Campbell, RN, Director</i>	TITLE Director	(X6) DATE 4/9/2014
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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 241	<p>Continued From page 1</p> <p>PM to be served and assisted with their noon meal. There was one Licensed Nursing Assistant (LNA) assigned to assist 11 residents, 3 that needed total help in the sunroom at the noon meal.</p> <p>Per interview with the LNA at 1:00 PM he/she confirmed that he/she was the only assigned staff member to assist residents in this dining area and that there are three residents to feed because they can not feed themselves and that the others have to wait until the LNA is done feeding one before another resident is fed. The LNA confirmed the other residents waiting to be fed just sit in the sunroom until the LNA can get to them or sometimes a floor nurse will help feed when they can.</p> <p>B) During observation of the evening meal on 03/17/14 Residents #15, #33, #40, #42, #53, #54, #55 & #84 waited greater than 1/2 hour - 45 minutes before being served and/or assisted with the meal. At approximately 4:46 PM in the main dining room staff were beginning to serve drinks. Resident #55's thickened drink was placed on the table but out of reach of the resident. The resident made several attempts to reach out for the drink, however, no staff assisted during the time period. Resident #42 was given a drink at 5:00 PM, however the resident watched another table mate being fed and was not fed until approximately 5:55 PM when it was brought to the attention of staff at that time. Residents #54 and #40 were wheeled to the table but staff did not assist with drinks, cue nor interact with the residents. Resident #84 who does pace during meals was standing over and watching two residents eat but was not re-directed, given snack and/or finger foods during this period of time.</p>	F 241	<p>Audit results will be presented to the QAA Committee for 3 months. Continuance and frequency of audits will be determined by the QAA committee.</p> <p>The DON will be responsible for the oversight of this plan.</p> <p>Corrective action to be complete by 4/19/2014.</p>		

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F 241	Continued From page 2 At approximately 5:45 PM, Resident #15 was complaining of back pain and requested a cup of tea. Multiple Licensed Nurse Aides (LNA's) were feeding other residents in the area, walked past Resident #15 and no assistance was offered nor was the resident's request met. Per interview on 3/17/14 at approximately 5:53 PM, RN Regional Quality Assurance Coordinator and the Director of Nurses (DNS) who were present at that time in the dining room confirmed that that eight residents are still waiting for their evening meal and that there is not enough staff to assist all the residents in the dining room. RN Regional Quality Assurance Coordinator also confirmed on 3/17/14 at approximately 6:15 PM, that s/he can not locate any policies or procedures in relation to the delivery of quality dining service. They confirmed that the dining experience for the above residents did not promote each resident's dignity and individuality. Also see F353.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure each resident's written plans of care are implemented	F 282	F282 483.20(k)(3)(ii) Residents #59 and 29 were not negatively affected by this alleged deficient practice. Residents requiring assistance with ADL's and positioning have the identified issues are addressed promptly and will meet weekly or as appropriate. Random observation audits will be completed weekly by the Executive Director or designee to monitor effectiveness of the plan. Audit results will be discussed at the Patient Safety Committee meeting weekly and at the QAA Committee for 3 months. The QAA Committee will determine continuance and frequency of the audits. Corrective action to be complete by 4/19/2014.	

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F 282	<p>Continued From page 3 for 2 of 21 residents in the sample (Residents #59 and #29) Findings include:</p> <p>1. Per observation on 03/17/14 during the evening meal and during the noon meal on 3/18/14 Resident #59 was noted to be in a reclining position. Staff during the meal time did not reposition the resident to an upright position during meals. Per review of the revised care plan dated 12/27/13, it directs staff to recline the Tilt in space wheelchair "unless taking food/liquids". Per interview on 03/19/14 at 10:10 AM the Unit Manager confirmed that staff did not follow the care plan by not repositioning the resident to an upright position during meals.</p> <p>2. Resident #29 was admitted on 11/27/12 with diagnoses to include Cerebral Vascular Accident, Muscle Weakness and Cardiovascular Disease. Per interview with Resident #29 on 03/17/14 at approximately 4 PM, s/he voiced that s/he is unable to brush her/his teeth or shave due to a weakened condition.</p> <p>Per Care Plan review on 03/18/14 Resident #29 has a self care deficit related to bathing, dressing, grooming, hygiene, toileting and eating. Staff are to provide supervision/assistance for mouth/dental care and provide extensive assist of one (1) for bathing, dressing, grooming and toilet or bedpan use. Designated interventions are assigned to Registered Nurse (RN), Licensed Practical Nurse (LPN) and/or Nurse Aide (NA).</p> <p>Per interview with Resident #29 on 03/18/14 at approximately 1:30 PM the resident stated that</p>	F 282	<div style="border: 1px solid black; padding: 5px;"> <p>potential to be affected by this alleged deficient practice.</p> <p>Education will be provided to staff regarding the provision of assistance to residents per the plan of care.</p> <p>Random audits will be performed weekly to monitor effectiveness of the plan by the DON or designee.</p> <p>The results of the audits will be reported to the QAA Committee for 3 months. The QAA Committee will determine continuance and frequency of audits.</p> <p>Corrective action to be complete by 4/19/2014.</p> </div> <p style="text-align: right; font-size: 1.2em;">POC - 282 accepted 4/14/14 Susan S. Emmons RN</p>

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F 323	<p>Continued From page 5</p> <p>The findings include;</p> <p>1. Per direct surveyor observation on 3/18/14 at 0915 AM, Resident #59 was in the sunroom on Unit 2 and was being pushed forward in his/her wheelchair by a facility Licensed Nursing Assistant (LNA) from the sunroom into the hallway on Unit 2. The LNA was observed pushing Resident #56 seated in a wheelchair, Resident #59 was observed to have both feet flat on the floor and was observed to be dragging his/her feet on the floor creating a loud scratching noise. The LNA was observed pushing the wheelchair past the nurses station with the resident's feet dragging on the floor, when the surveyor observed the left foot of Resident #59 bend backward under the wheelchair and hit the front left tire of the wheelchair. Resident #59 screamed out in pain. The LNA was then observed to stop the wheelchair, move Resident #59's left foot back flat on the floor and preceded to push the wheelchair again, dragging both the resident's feet to the medication cart. At no time was the LNA observed to ask the resident to lift his/her feet as the aide pushed the wheelchair forward. The LNA was then observed to go notify the nurse. The Liscensed Practical Nurse (LPN) was observed to approach the resident and take the resident, still seated in the wheelchair, and push the resident forward in the wheelchair as Resident #59 dragged his/her feet on the floor to the resident's room.</p> <p>Per interview with the LNA who was pushing Resident #59 in the wheelchair on 3/18/14 at approximately 920 AM, he/she indicated that there were no foot rests on the wheelchair because resident #59 self propels (moves wheelchair with his/her feet) sometimes. The LNA</p>	F 323		

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F 323	<p>Continued From page 6</p> <p>confirmed he/she was pushing Resident #59 in the wheelchair forward while the resident was dragging his/her feet and Resident #59's left foot bent backward into the front left tire of the wheelchair causing Resident #59 to yell out in pain. The LNA indicated that sometimes Resident #59 won't pick up his/her feet and they slide on the floor when Resident #59 is being transported.</p> <p>Per interview with the Staff Educator on 3/18/14 on Unit 2 at the medication cart, he/she confirmed that for transporting a resident from one location to another it would be beneficial to utilize leg rests on the wheelchair to prevent injury. The Staff Educator confirmed that Resident #59 has a habit and history of dragging his/her feet. The Staff Educator and Surveyor observed the LPN pushing Resident #59 down the hallway to the resident's room without leg rests on the wheelchair, the Staff Educator confirmed that Resident #59 was dragging his/her feet as he/she was being pushed forward and that this could cause a potential injury to Resident #59's feet.</p> <p>Per review of the medical record for Resident #59, it indicated that on 3/18/2014 10:35 : "Pt was being brought back from dining room after breakfast, and she yelled out front wheel had hit her left ankle bone...area on left ankle bone is a scrape measuring 1/2 cm x 1/2 cm, no drainage."</p> <p>Per interview with the Contracted Therapy Manager, on 3/18 and 3/19/14, he/she indicated that it is his/her expectation that "leg rests should be used for every resident...when staff is transferring the resident in the wheelchair from one location to another". The Contracted Therapy Manager on 3/18/14 indicated in interview that</p>	F 323		

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F 323	<p>Continued From page 7</p> <p>direct care staff had not been educated regarding the expectation that "leg rests should be used for every resident whether they can self propel a wheelchair when staff is transferring the resident in the wheelchair from one location to another".</p> <p>Per interview on 3/18/14 and again on 3/19/14 the Contracted Therapy Manager stated that a Nurse Consultant hired by the facility Administration had "informed Administration a while ago (maybe a month) that the facility had a potential problem because residents were being transferred in wheelchairs to and from locations without wheelchair leg rests being used".</p> <p>Per interview with Regional Quality Assurance Coordinator on 3/19/14, he/she indicated that approximately 3-4 weeks prior to 3/18/14 a Nurse Consultant hired by the facility to identify areas of concern communicated to Administration that residents were being transferred in wheelchairs to and from locations without wheelchair leg rests being used. The Regional Quality Assurance Coordinator confirmed that "the issue was on their radar since the issue was identified 3-4 weeks ago" and that an audit had been completed and provided to Administration on 3/17/14 to identify residents in the facility who have or need wheelchair leg rests, but that nothing else had been completed to address the transport of residents without leg rests since the Administration was notified 3-4 weeks prior to the 3/18/14 incident with Resident #59.</p>	F 323		
F 353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or</p>	F 353		

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F 353	<p>Continued From page 8</p> <p>maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to assure that there was sufficient staff to provide nursing and related services to maintain the highest practicable well-being for residents. Findings include:</p> <p>During observation of the dining experiences, Residents were not assisted with their meals and/or drinks in a timely manner. During the evening meal on 03/17/14, six Residents waited from 4:46 PM to approximately 5:53 PM, nearly an hour after other resident were eating or fed, before being served and/or assisted with their meal.</p> <p>Per interview on 3/17/14 at approximately 5:53</p>	F 353	<p>F353 483.30 (a)</p> <p>No residents were negatively affected by this alleged deficient practice.</p> <p>Residents requiring assistance with meals have the potential to be affected by this alleged deficient practice.</p> <p>The dining process has been revised and education provided to staff regarding the new process.</p> <p>Random audits will be done by the DNS or designee 3X weekly to monitor effectiveness of the plan.</p> <p>The results of the audits will be presented to the QAA Committee for 3 months. The QAA Committee will determine continuance and frequency of audits.</p> <p>Corrective action to be complete by 4/19/2014.</p> <p><i>Poc F353 accepted 4/14/14 Susan J. Emmons RN</i></p>	

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F 353	Continued From page 9 PM, the RN Regional Quality Assurance Coordinator and the Director of Nurses who were present in the dining room confirm that that six (6) residents are still waiting for their evening meal and that there is not enough staff to assist all the residents in the dining room. RN Regional Quality Assurance Coordinator also confirms on 3/17/14 at approximately 6:15 PM, that s/he can not locate any policies or procedures in relation to the delivery of quality dining service.	F 353		
F 371 SS=E	Also see F241. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: During the initial kitchen tour with the Dining Director on 3/17/14 at 9:30 AM, the following observations were made.	F 371	F371 483.35(i) No residents were negatively affected by this alleged deficient practice Residents residing in the facility have the potential to be affected by the alleged deficient practice. The two large wire racks, the window screens and sills above the snack carts, the ceiling intake vent and the top surface of the exhaust hood were all cleaned of debris and dust. A cleaning schedule has been revised to include the items listed and education provided to staff. Random audits will be completed by the Food Service Director weekly with remedial measures initiated as needed to monitor effectiveness of the plan. Audit results will be reported to the QAA Committee for 3 months. The QAA committee will determine the continuance and frequency of	

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F 371	Continued From page 10 1. Two large wire racks with clean dishes and hotel pans stored on them were heavily soiled with dust. 2. Window screens and sills directly above a snack cart were heavily soiled with debris and dead insects. 3. An operating ceiling intake vent was heavily soiled with dust. At second observation on 3/19/14, the ceiling vent was still heavily soiled and there was a container of meat positioned on a counter directly under the vent. Per interviews with both the Dining and Maintenance Directors, the ceiling vents were not on a routine cleaning schedule. 4. The top surface of an exhaust hood over a stove was soiled with grease and dust. The above observations were confirmed by the Dining Director at the time of the observations.	F 371	audits. <i>POC F371 accepted 4/14/14</i> Corrective action to be complete by 4/19/2014. <i>Sum J. Emmo RN</i> F441 483.65 No residents were negatively affected by this alleged deficient practice. Residents residing in the facility have the potential to be affected by this alleged deficient practice. Education will be provided to staff regarding infection prevention. All resident's wheelchairs have been cleaned and a schedule has been developed for cleaning wheelchairs. Education will be provided to staff regarding the schedule and process for cleaning wheelchairs.
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	Random audits will be conducted 3X weekly by the DON or designee to monitor effectiveness of the plan. Audit results will be reported to the QAA committee for 3 months. The QAA committee will determine continuance and frequency of audits. Corrective action to be complete by 4/19/2014. <i>POC F441 accepted 4/14/14</i> <i>Sum J. Emmo RN</i>

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F 441	<p>Continued From page 11</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews for 7 applicable residents during the three days of survey, March 17 through March 19, 2014, the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (Residents #15, #22, #29, #33, #53 and #103) The findings include:</p> <p>1. Per observation during the noon meal on 3/17/14 at 12:38 PM, an LPN was assisting Resident #33 to eat his/her noon meal. It was</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475037	(X2) MULTIPLE CDNSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2014
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 441	<p>Continued From page 12</p> <p>observed that the LPN was holding a slice of Resident's bread in his/her bare hand. Another nurse approached the LPN and asked for the medication cart keys. The LPN, placed the bread on the plate, reached into his/her pocket and grabbed the medication keys and handed them to the other nurse. The LPN then picked up the bread from the plate with the same hand he/she had used to touch the medication keys and fed it to the resident. The LPN did not wash his/her hands before feeding the bread to the Resident.</p> <p>Per observation at 12:50 PM, the LPN was observed serving Resident #33 a brownie. The LPN was using his/her bare right hand to feed the brownie to Resident #33. Another resident was yelling and the LPN walked to the other resident and was observed rubbing the yelling resident on the back. The LPN then returned to Resident #33 and picked up the brownie with his/her bare right hand and continued to feed the resident. The LPN did not wash his/her hands after rubbing the other resident's back and picking up the brownie that was fed to Resident #33.</p> <p>Per interview with the LPN at 1:05 PM, the LPN stated he/she was unaware that he/she needed to wash his/her hands after touching keys or someone's clothing before proceeding to feed another resident with the same hand.</p> <p>Per interview with the Staff Educator all nursing employees are educated on handwashing techniques and guidelines on how to assist a resident when they are being fed.</p>	F 441		

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F 441	Continued From page 13 2. Per observation and interview with Resident #29 on 3/17/14 at 4 PM, his/her personal wheelchair, wheelchair cushion and wheelchair arm rests were noted to have dried food, liquids and other particles caked on surfaces. Per direct observation on 3/17/14 by two surveyors, the wheelchair for Resident #15 was observed at 1:50 PM to be covered with dry food material on the wheelchair arms and seat. Per observation on 3/18/14 by two surveyors, the wheelchairs for Resident #15, #103, #22, #33, #53 and #29, were observed to be covered with dry food material on the arm rests. Per interview with the Unit Manager (UM) on 3/17/14 at 4:30 PM s/he confirms that the chair is filthy and that nursing staff are responsible for cleaning resident's equipment that is dirty. Per interview with the RN Regional Quality Assurance (QA) Coordinator and the UM on 3/19/14 at approximately 9 AM, they confirm that there are no policies or procedures regarding wheel chair cleaning nor can they locate any assignment for staff that identifies the task of cleaning wheelchairs.	F 441			
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	F490 483.75 Resident #59's scrape resolved without complications. Resident #59 was re-evaluated by therapy and footrests issued. Residents requiring assistance with transport in a wheelchair have the potential to be affected by this alleged deficient practice. All residents utilizing wheelchairs have been issued foot rests to be used during transport and education provided to staff. A Patient Safety Committee has been developed to ensure		

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F 490	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility administration failed to address a resident safety issue brought to their attention in a timely manner, resulting in potentially avoidable pain and discomfort for 1 applicable resident (Resident #59) and the issue has the potential to affect all residents who are transported by staff in wheelchairs. The findings include;</p> <p>1. Per direct surveyor observation on 03/18/14 at 0915 AM, Resident #59 was in the sunroom on Unit 2 and was being pushed forward in his/her wheelchair by a facility Licensed Nursing Assistant (LNA) from the sunroom into the hallway on Unit 2. The LNA was observed pushing the wheelchair past the nurses station with the resident's feet dragging on the floor, the surveyor observed the left foot of Resident #59 bend backward under the wheelchair and hit the front left tire of the wheelchair. Resident #59 screamed out in pain. The LNA was then observed to stop the wheelchair, move Resident #59's left foot back flat on the floor and preceded to push the wheelchair again, dragging both the resident's feet to the medication cart. At no time was the LNA observed to ask the resident to lift his/her feet as the aide pushed the wheelchair forward. The LNA was then observed to go notify the nurse. The Licensed Practical Nurse (LPN) was observed to approach the resident and take the resident, still seated in the wheelchair, and push the resident forward in the wheelchair again as Resident #59 dragged his/her feet on the floor to the resident's room.</p> <p>Per review of the medical record for Resident</p>	F 490	<p>identified issues are addressed promptly and will meet weekly or as appropriate.</p> <p>Random observation audits will be completed weekly by the Executive Director or designee to monitor effectiveness of the plan.</p> <p>Audit results will be discussed at the Patient Safety Committee meeting weekly and at the QAA Committee for 3 months. The QAA Committee will determine continuance and frequency of the audits.</p> <p>Corrective action to be complete by 4/19/2014.</p> <p><i>DIC F-490 accepted 4/14/14</i> <i>Juan S. Emma RN</i></p>	
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F 490	<p>Continued From page 15</p> <p>#59, it indicated that on 03/18/2014 at 10:35 AM: "Pt was being brought back from dining room after breakfast, and she yelled out front wheel had hit her left ankle bone...area on left ankle bone is a scrape measuring 1/2 cm x 1/2 cm, no drainage."</p> <p>Per interview with the Contracted Therapy Manager, on 03/18 and 03/19/14, he/she indicated that it is his/her expectation that "leg rests should be used for every resident...when staff is transferring the resident in the wheelchair from one location to another". Per interview on 03/18/14 and again on 03/19/14 the Contracted Therapy Manager stated that a Nurse Consultant hired by the facility Administration had "informed Administration a while ago (maybe a month) that the facility had a potential problem because residents were being transferred in wheelchairs to and from locations without wheelchair leg rests being used".</p> <p>Per interview with Regional Quality Assurance Coordinator on 03/19/14, he/she indicated that approximately 3-4 weeks prior to 03/18/14 a Nurse Consultant hired by the facility to identify areas of concern communicated to Administration that residents were being transferred in wheelchairs to and from locations without wheelchair leg rests being used. The Regional Quality Assurance Coordinator confirmed that "the issue was on their radar since the issue was identified 3-4 weeks ago" and that an audit had been completed and provided to Administration on 03/17/14 to identify residents in the facility who have or need wheelchair leg rests, but that nothing else had been completed to address the transport of residents without leg rests since the Administration was notified 3-4 weeks prior to the</p>	F 490		

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F 490	Continued From page 16 03/18/14 incident with Resident #59. Also see F323.	F 490			