

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

June 4, 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 **May 13, 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

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 05/13/2014
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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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(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 000 F 223 SS=G	<p>INITIAL COMMENTS</p> <p>An unannounced onsite investigation into three facility self-reports and two complaints was conducted by the Division of Licensing and Protection from 5/12 - 5/13/14. The following regulatory violation was identified, 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure that residents were free from abuse for three of four residents sampled (Residents #1, #2, and #3). Findings include: Per observation, interview, and record review on 5/12 - 5/13/14, Residents #1, #2, and #3 have advanced dementia, and require extensive assistance with many activities of daily living. According to written statements of staff, on the afternoon/evening of 2/15/14, an newly hired Licensed Nursing Assistant (LNA #1) was orienting with an experienced LNA #2, working as a team to prepare residents for supper by getting them up from bed, and/or toileting them. According to the written statement of LNA #1, they were providing care to Resident #1 by</p>	F 000 F 223	<p>Preparation and/or execution of the 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 223 483.13(b)</p> <p>Residents #1, 2, and 3 had no negative effect as a result of this alleged deficient practice.</p> <p>Resident residing in the facility have the potential to be affected by alleged deficient practice.</p> <p>Education has been and will be provided to staff regarding resident abuse and reporting.</p> <p>Audits will be done minimum of 2x weekly by the DON or designee to monitor effectiveness of the plan.</p> <p>Audit results will be presented at QAA Committee for 3 months. The QAA Committee will determine continuance and frequency of the audits.</p>	

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

Ann Campbell Executive Director

Corrective action to be completed by
June 13 2014

(X6) DATE
6/2/14

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.

F223 POC accepted 6/10/14 pmustapen

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F 223	<p>Continued From page 1</p> <p>transferring them by mechanical lift to the bed to be checked for incontinence. Per the written statement, LNA #2 had the mechanical lift bar so tight against the resident's legs that the resident cried out in pain, and LNA #2 said to Resident #1, "Shut up (name), we are helping you cuz you're wet". The resident reacted by drawing back a fist and swearing at LNA #2. LNA #1 stated that the resident was treated roughly "manhandled" after that by LNA #2. The written statement also went on to say that Resident #1 was so upset that they did not want to eat supper.</p> <p>The next incident described in LNA #1's written statement was pertaining to the provision of care to Resident #2. They described LNA #2's assistance with toileting of the resident as roughly tossing him/her around like a rag doll, grabbing them under the arms, yanking him/her off the toilet, and yelling at Resident #2 to "stand up, stand up", to which the resident replied "I can't stand up any higher." LNA #1 was pulling up his/her pants and stated that Resident #2 had a frightened look on their face and was almost in tears. LNA #1 wrote that s/he told LNA #2 to go easy because s/he was frail, and LNA #2 replied that they needed to hurry and get them up.</p> <p>The third example given in the written statement was regarding Resident #3, who allegedly was dragged by the arms/hands to the sitting position without the use of a gait belt. At that time LNA #1 told the other LNA to be gentle but was ignored.</p> <p>LNA #1 asked another LNA if they had ever witnessed any rough treatment of the residents by LNA #2 and they said no. LNA #1 went to the Licensed Practical Nurse (LPN) on duty on that wing and reported the rough treatment. There</p>	F 223		

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F 223	<p>Continued From page 2</p> <p>were no specific timelines for each of these incidents in the written statement of the LNA, however s/he only worked from 3-5 PM.</p> <p>Per review of the written statement of the LPN working on that hall on 2/15/14, s/he stated that they arrived at 4:30 PM for their shift, and LNA#1 and #2 were assisting residents as a team preparing them for supper. LNA #1 approached him/her and asked if LNA #2 was usually rough with residents, and the LPN replied "Do you mean that [s/he] doesn't know their own strength while caring for them?" as a clarification, and LNA #1 said no that s/he had been rough while handling Resident #2. The LPN told LNA #1 that s/he would report this to the acting supervisor on duty, a Registered Nurse.</p> <p>Per the written statement by the RN supervisor, the LPN spoke to him/her at about 6:30 PM, vaguely asking about an LNA being rough with a patient. When the RN inquired who they were speaking of, the LPN stated that it was LNA #2 and that they think they do not know their own strength. When the supervisor asked the LPN if they felt the residents were in danger of being harmed, the nurse replied "well, no." After supper, at approximately 7:30 PM, the RN supervisor approached the LPN and asked if they knew what the procedure was if they felt someone was being abused, and the LPN shook their head yes, as the RN supervisor continued to explain "first you remove the staff member immediately, call the Director of Nursing and Administrator, and assess the resident completely." The LPN nodded in agreement, and the RN stated that the LPN did not approach them again that evening.</p> <p>LNA #2 continued to work the remainder of</p>	F 223		

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F 223	Continued From page 3 his/her scheduled shift, caring for residents with no further incidents reported by other LNAs who were partnered with him/her that evening. It was the following morning on 2/16/14 that LNA #1 told another nurse working the day shift what had happened the evening before, and this nurse told a supervisor who apparently called the Director of Nursing. LNA #2 was scheduled to work later that day, however was suspended and did not come in again, and was terminated from employment after the incident was investigated. Per interview on 5/13/14 at 2:15 PM, the Regional Manager who had been the acting Director of Nursing in February 2014 confirmed that any allegation of abuse should have been reported immediately to the DNS, and the employee sent home for protection of the residents. S/he also confirmed that LNA #1, LNA #2, and all nursing staff involved had attended inservices regarding abuse reporting protocols, and that the protocol for protecting residents had not been followed.	F 223			