

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 7, 2013

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

Dear Mr. Hunter:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 15, 2013**. 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: 05/29/2013
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 05/15/2013
NAME OF PROVIDER OR SUPPLIER ROWAN 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 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was conducted by the Division of Licensing and Protection from 5/14/13 through 5/15/13. Regulatory violations were cited as follows related to the allegations in the complaint. Immediate Jeopardy with Substandard Quality of Care was determined to exist.	F 000	Rowan Health & Rehab provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	<u>F 157</u> Corrective action accomplished for those residents found to have been affected; Resident #1 no longer resides at the facility. How the center will identify other residents having the potential to be affected by the same deficient practice and the corrective action that has been taken; Residents of the center are identified as having the potential to be affected. An audit of residents in house was conducted to determine if there is documented evidence of physician notification when a resident needs an alteration in treatment. Corrective action was taken, nursing staff notified the physician, when the audit showed that there was a need.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Marc A. Hunter
TITLE
EXECUTIVE DIRECTOR
(X8) DATE
5-30-2013

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.

PM

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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to notify the physician of a need to alter treatment significantly for one of four residents in the sample (Resident #1). Findings include:</p> <p>1. Per record review on 5/14/13, Resident #1 was admitted to the facility on 4/30/13 from hospital for short term rehabilitation after having fallen at home and sustaining a chest injury. S/he had been living at home with home health services and help from family, and had recently had a ramp built onto the home. Upon nursing home admission, diagnoses included pneumonia, azotemia (a condition which causes high nitrogen levels in the blood and compromised kidney function), dementia with behavioral disturbance, Chronic Obstructive Pulmonary Disease (COPD), cellulitis, dysphagia oropharyngeal phase (difficulty swallowing), hypertension, tremors, cardiovascular disease, and anxiety.</p> <p>The medical record included a nursing plan of care dated 4/30/13. This admission plan of care included the following section: "Fluid volume deficit related to: azotemia/dementia: assess for dehydration, monitor intake and output, encourage PO (by mouth) fluids, and medications as ordered". The Registered Dietician (RD) conducted an admission nutrition assessment on 5/1/13. This assessment estimated the fluid</p>	F 157	<p>How the corrective actions will be monitored to ensure that the deficient practice does not recur including QA programs;</p> <p>Unit Managers and Nursing Supervisors are responsible for ensuring that MD notification is done as needed. Ongoing, the MD Notification audit will be conducted five times per week with remedial measures initiated as needed. Findings and trends of the completed audits will be reported to the QA committee with additional recommendations as necessary.</p> <p>DNS shall have the responsibility to monitor this individual plan of correction.</p> <p>Completion date is May 27, 2013</p> <p>F157 POC accepted 6/6/13 JHsmerrn/pmc</p>	

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F 157	<p>Continued From page 2</p> <p>intake needs of Resident #1 as 1,500 cc to 1,700 cc (1 cc=1 milliliter) per day. Fluid intake records provided by the facility documented the following daily fluid intake totals: 4/30/13 120 cc; 5/1/13 420 cc; 5/2/13 240 cc; 5/3/13 420 cc; 5/4/13 480 cc; 5/5/13 0/no entry.</p> <p>On 5/3/13, Resident #1 was noted in day shift nursing progress notes as having difficulty keeping in the mouth the crushed medications taken with pudding and water. On 5/4/13, the day shift nursing progress notes documented that Resident #1 was observed having difficulty swallowing foods and liquid, with frequent coughing. The facility did obtain on 5/2/13 an evaluation by the Speech Language Pathologist (SLP) who recommended treatment and staff assistance with eating and drinking. There was evidence that the dietary slip and care plan changed to staff assistance from independent eating. However, on 5/15/13 neither the charge nurse, nor the Director of Nursing (DON), nor the physician's office could provide evidence that the physician had been informed regarding the low oral fluid intake since admission, nor the difficulty with swallowing medication, food and drink on 5/3 and 5/4.</p> <p>On the morning of 5/5/13 at 10:30 AM, per record review, Resident #1 was found by the nurse to be unresponsive. Resident #1 was transported emergently to hospital where the physician documented him/her to "appear extremely dehydrated" and "lab values significant for severely elevated creatinine of 3.8 [high, kidneys not working well], hypernatremia [high sodium, indicator of dehydration] of 151". Further in the physician's report of 5/5/13, comments include:</p>	F 157	<p>Measures put into place by the center and systemic changes the center has made to ensure that the deficient practice does not recur;</p> <p>Licensed Nurses have been educated regarding physician notification to obtain an alteration in treatment, related to residents with an inadequate fluid intake. An MD Notification verification process was developed and implemented to include listing each resident with a change in condition or a need to alter treatment during concurrent review. The Unit Manager or designee then conducts a medical record review to verify that the physician was notified with remedial measure initiated when needed. Staff are provided with re-education and/or counseling as identified from the results of the MD notification audits.</p>	

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F 157	<p>Continued From page 3</p> <p>"Further evaluation also reveals that [s/he] has acute kidney injury on chronic kidney disease and hypernatremia (high sodium in the blood). These are most likely due to dehydration." Hospital records of 5/5/13 also indicate that Resident #1 was admitted to the Intensive Care Unit. During an interview on 5/15/13 at 11:25 AM, the DON confirmed that the facility could not provide evidence that nursing staff had informed the physician of the low oral fluid intake since admission to the nursing home facility.</p> <p>Per interview with the physician in charge of Resident #1's care on 5/17/13 at 8:48 AM, the physician confirmed that s/he had no evidence of and also did not recall being notified by facility staff of the inadequate fluid intake. The physician had recorded notes regarding conversations with facility staff, but indicated the conversation on 5/3/13 with the staff was focused around the Resident's restlessness and agitation. The physician specifically stated that the labs that were ordered by him/her were due to the behavioral changes, and not because s/he had been informed that the resident was not taking adequate fluids. The physician indicated that if s/he had been informed on 5/3/13 of the intake totals, s/he would have taken action.</p>	F 157	<p>F 282</p> <p>Corrective action accomplished for those residents found to have been affected;</p> <p>EMR username and passwords were obtained for all agency nursing staff as of May 22, 2013. No staff member will be permitted to care for residents without having full and complete access to the EMR.</p> <p>How the center will identify other residents having the potential to be affected by the same deficient practice and the corrective action that has been taken;</p> <p>Residents of the center are identified as having the potential to be affected. Agency nursing staff has been provided with education on PCC and POC EMR systems and their successful completion of return demonstration skills competency prior to being assigned to care for residents.</p>	
F 282 SS=J	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 282		

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F 282	<p>Continued From page 4</p> <p>by: Based on record review and interviews, the facility failed to fully implement the nursing plan of care for risk of fluid volume deficit for one of four residents in the sample (Resident #1). Findings include:</p> <p>1. Per record review on 5/14/13, Resident #1 was admitted to the facility on 4/30/13 from hospital for short term rehabilitation after having fallen at home and sustaining a chest injury. S/he had been living at home with home health services and help from family, and had recently had a ramp built onto the home. Per record review on 5/14/13, Resident #1 was admitted to the facility on 4/30/13 from hospital with diagnoses including pneumonia, azotemia (a condition which causes high nitrogen levels in the blood and compromised kidney function), dementia with behavioral disturbance, Chronic Obstructive Pulmonary Disease (COPD), cellulitis, dysphagia oropharyngeal phase (difficulty swallowing), hypertension, tremors, cardiovascular disease, and anxiety.</p> <p>The medical record included a nursing plan of care dated 4/30/13. This admission plan of care included the following section: "Fluid volume deficit related to: azotemia/dementia: assess for dehydration, monitor intake and output, encourage PO (by mouth) fluids, and medications as ordered". The Registered Dietician (RD) conducted an admission nutrition assessment on 5/1/13. This assessment estimated the fluid intake needs of Resident #1 as 1,500 cc to 1,700 cc (1 cc=1 milliliter) per day. Fluid intake records provided by the facility documented the following daily fluid intake totals: 4/30/13 120 cc; 5/1/13</p>	F 282	<p>Measures put into place by the center and systemic changes the center has made to ensure that the deficient practice does not recur;</p> <p>Staff who are new to Rowan Health & Rehab will have EMR username, password, and complete the PCC orientation with return demonstration prior to being assigned to care for residents. The Executive Director will ensure that access is granted as needed.</p> <p>How the corrective actions will be monitored to ensure that the deficient practice does not recur including QA programs;</p> <p>Random audits are being conducted to monitor agency nursing staff knowledge and usage of the EMR with remedial measures, including additional education, initiated as identified. This will be done weekly x4 and then monthly x3 or until substantial compliance is met. Findings and trends will be reported to the QA committee with additional recommendations as necessary.</p>		

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F 282	<p>Continued From page 5</p> <p>420 cc; 5/2/13 240 cc; 5/3/13 420 cc; 5/4/13 480 cc; 5/5/13 0/no entry. From 4/30/13 to 5/5/13 there were no recorded entries regarding urinary output.</p> <p>On 5/3/13, Resident #1 was noted in day shift nursing progress notes as having difficulty keeping in the mouth the crushed medications taken with pudding and water. On 5/4/13, the day shift nursing progress notes documented that Resident #1 was observed having difficulty swallowing foods and liquid, with frequent coughing. The facility did obtain on 5/2/13 an evaluation by the Speech Language Pathologist (SLP) who recommended treatment and staff assistance with eating and drinking due to slow and laborious swallow efforts and choking. There was evidence that the dietary slip and care plan changed to staff assistance for eating from independent status upon admission. However, on 5/15/13 neither the charge nurse, nor the Director of Nursing (DON), nor the physician's office could provide evidence that the physician had been informed regarding the low oral fluid intake since admission, nor the difficulty with swallowing medication, food and drink on 5/3 and 5/4.</p> <p>On the morning of 5/5/13, at 10:30 AM, per record review, Resident #1 was found by the nurse to be unresponsive. Resident #1 was transported emergently to hospital where the physician documented him/her to "appear extremely dehydrated" and "lab values significant for severely elevated creatinine of 3.8 [high, kidneys not working well], hypernatremia [high sodium, indicator of dehydration] of 151". Further in the physician's report of 5/5/13, comments include: "Further evaluation also reveals that [s/he] has</p>	F 282	<p>Executive Director shall have the responsibility to monitor the plan of correction.</p> <p>Completion date is May 27, 2013</p> <p><i>F282 POC accepted 6/6/13 JHosmer RN/Pme</i></p>

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F 282	Continued From page 6 acute kidney injury on chronic kidney disease and hypernatremia [high sodium in the blood]. These are most likely due to dehydration." Hospital records of 5/5/13 also indicate that Resident #1 was admitted to the Intensive Care Unit. During an interview on 5/15/13 at 10:40 AM, the DON confirmed that the facility did not have a system of oversight in place to assure monitoring of daily oral intake values as per the written plan of care for risk of fluid volume deficit.	F 282	F 327 Corrective action accomplished for those residents found to have been affected; Resident # 1 no longer resides at the facility. On May 21, 2013, the facility developed a system to assure that fluid intake totals are reviewed and that fluid intake is documented.	
F 327 SS=J	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide one of four residents in the sample (Resident #1) with sufficient fluid intake to maintain proper hydration and health. Findings include: 1. Per record review on 5/14/13, Resident #1 was admitted to the facility on 4/30/13 from hospital for short term rehabilitation after having fallen at home and sustaining a chest injury. S/he had been living at home with home health services and help from family, and had recently had a ramp built onto the home. Upon nursing home admission, diagnoses included pneumonia, azotemia (a condition which causes high nitrogen levels in the blood and compromised kidney function), dementia with behavioral disturbance, Chronic Obstructive Pulmonary Disease (COPD),	F 327	 How the center will identify other residents having the potential to be affected by the same deficient practice and the corrective action that has been taken; Residents of the center are identified as having the potential to be affected. On May 15, 2013, a registered nurse conducted a physical assessment for dehydration on each resident. Additionally, a dehydration risk screening assessment was completed for each resident in house. An audit of each resident identified as having symptoms of dehydration or have a high risk of dehydration was conducted. Measures put into place by the center and systemic changes the center has made to ensure that the deficient practice does not recur;	

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F 327	<p>Continued From page 7</p> <p>cellulitis, dysphagia oropharyngeal phase (difficulty swallowing), hypertension, tremors, cardiovascular disease, and anxiety.</p> <p>The medical record included a nursing plan of care dated 4/30/13. This admission plan of care included the following section: "Fluid volume deficit related to: azotemia/dementia: assess for dehydration, monitor intake and output, encourage PO (by mouth) fluids, and medications as ordered". The Registered Dietician (RD) conducted an admission nutrition assessment on 5/1/13. This assessment estimated the fluid intake needs of Resident #1 as 1,500 cc to 1,700 cc (1 cc=1 milliliter) per day. Fluid intake records provided by the facility documented the following daily fluid intake totals: 4/30/13 120 cc; 5/1/13 420 cc; 5/2/13 240 cc; 5/3/13 420 cc; 5/4/13 480 cc; 5/5/13 0/no entry.</p> <p>On 5/3/13, Resident #1 was noted in day shift nursing progress notes as having difficulty keeping in the mouth the crushed medications taken with pudding and water. On 5/4/13, the day shift nursing progress notes documented that Resident #1 was observed having difficulty swallowing foods and liquid, with frequent coughing. The facility did obtain on 5/2/13 an evaluation by the Speech Language Pathologist (SLP) who recommended treatment and staff assistance with eating and drinking due to slow and laborious swallow and choking. There was evidence that the dietary slip and care plan changed to staff assistance for eating from independent eating upon admission. However, on 5/15/13 neither the charge nurse, nor the Director of Nursing (DON), nor the physician's office could provide evidence that the physician had been</p>	F 327	<p>Staff has been educated on the hydration monitoring policy and process. Nursing staff was educated on documenting fluid intake into the EMR (Point of Care System). A revised Hydration Monitoring system/protocol was implemented. The protocol includes LNAs and Nurses documenting intake in the EMR and utilizing a paper form for those resident's identified as needing additional I&O monitoring. Unit Managers and Nursing Supervisors will review each resident's fluid intake each morning and implement actions based upon findings. Additionally, a look back report for fluid intake will be reviewed three times per week by the nursing team. This team reviews resident fluid intake for residents in house and residents requiring additional I&O monitoring and makes adjustments with supporting documentation as identified. Resident found to have consumed less than their estimated fluid needs or have a current condition that warrants additional I&O monitoring are assessed for signs and symptoms of dehydration, physician notified of the low intake and signs/symptoms, dietician notification, and the resident's care plan is reviewed and revised as needed. Weekly, as part of At Risk meeting, a list of estimated fluid needs will be reviewed by the interdisciplinary team.</p>	

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F 327	Continued From page 8 informed regarding the low oral fluid intake since admission, nor the difficulty with swallowing medication, food and drink on 5/3 and 5/4. On the morning of 5/5/13 at 10:30 AM, per record review, Resident #1 was found by the nurse to be unresponsive. Resident #1 was transported emergently to hospital where the physician documented him/her to "appear extremely dehydrated" and "lab values significant for severely elevated creatinine of 3.8 [high, kidneys not working well], hypernatremia [high sodium, indicator of dehydration] of 151". Further in the physician's report of 5/5/13, comments include: "Further evaluation also reveals that [s/he] has acute kidney injury on chronic kidney disease and hypernatremia [high sodium in the blood]. These are most likely due to dehydration." Hospital records of 5/5/13 also indicate that Resident #1 was admitted to the Intensive Care Unit. Further review of the hospital record reveals that after receiving at least 2 liters of Intravenous fluids at the hospital, Resident #1's creatinine at 7:35 AM on 5/6/13 improved (decreased) to 3.3. During an interview on 5/15/13 at 10:40 AM, the DON confirmed that there was not a system in place to assure that daily fluid intake totals were reviewed. Additionally, in an interview at 11:25 AM, the DON confirmed that the facility could not provide evidence that nursing staff had informed the physician of the low oral fluid intake since admission.	F 327	How the corrective actions will be monitored to ensure that the deficient practice does not recur including QA programs; Residents' fluid intakes will audited 3x/week for four weeks, then monthly x 3 or until substantial compliance is met. Findings and trends will be reported to the QA committee with additional recommendations as necessary. DNS shall have the responsibility to monitor this individual plan of correction. Completion date: May 27, 2013 F327 POC accepted 6/6/13 JHsmer RN/ame	