

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

October 21, 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 **September 19, 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: 09/30/2013
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 09/19/2013
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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
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F 000

INITIAL COMMENTS

F 000

An unannounced onsite investigation of an entity reported incident was completed by the Division of Licensing and Protection on 9/19/13. Based on information gathered, the following regulatory violations were cited.

F 221
SS=G

483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

F 221

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

Corrective Action

F 221

This REQUIREMENT is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to assure that one of three residents in the sample (Resident #1) remained free of physical restraints imposed for purposes of convenience and not required to treat the resident's medical symptoms. Findings include:

#1. Resident #1 has been assessed, no further injuries have been observed and the bruises are resolving. LNA's A, B & C are no longer employed by this Center.

#2. All residents who exhibit resistance to care are at risk to be affected by this alleged deficient practice.

1. On 9/19/13, the surveyor reviewed the facility's internal investigation documents, written staff statements, and the medical record of Resident #1. Resident #1 (who is age 102 years) is assessed and care planned for urinary incontinence, anxiety, behaviors such as hitting, yelling, and throwing things, intermittent resistance to care, and forgetfulness related to advanced age. Resident #1 is assessed and care planned for transfer by two staff using a stand and pivot technique.

#3. Staff have been re-educated regarding the policy on restraint use and as to alternative approaches to be utilized with residents exhibiting behaviors.

Written evidence indicates that during the

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

TITLE

(X6) DATE

Maria G. [Signature]

EXECUTIVE DIRECTOR

10-3-2013

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.

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NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 371 PROSPECT STREET BARRE, VT 05641
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F 221	<p>Continued From page 1</p> <p>evening of 9/15/13, Resident #1 was agitated, hallucinatory, and resistive to care by nursing staff (as evidenced by yelling at staff and throwing things). Witness statements by the nurse on duty that evening, and three Licensed Nurse Assistants (LNAA, B, and C) who were on duty, indicate that Resident #1 had been incontinent of urine and had resisted multiple approaches and efforts to clean and change him/her during the evening shift. In a statement dated 9/16/13, the nurse related that s/he was unable to administer an as needed dose of an anti-anxiety medication (lorazepam) and instructed staff to allow Resident #1 to calm down.</p> <p>Written statements by LNA staff A, B, and C, as well as interview and re-education documentation by the Assistant Director of Nurses (ADNS), indicate that the three LNA staff elected to provide personal care to Resident #1, despite having been instructed by the nurse to let him/her calm down. Further, LNAA elected to wrap Resident #1 around the hands and feet with a draw sheet before moving him/her, allegedly to prevent harm during combativeness. The three LNA staff transferred Resident #1 from the wheelchair to the bed while wrapped in draw sheet, then removed the sheet. At this time, LNAs A and C held the arms of Resident #1 while LNA C changed the wet brief and provided personal hygiene.</p> <p>On 9/19/13 at 9:45 AM, Resident #1 was observed to have purple bruising on the left and right wrist areas. When asked how this happened, Resident #1 stated to this surveyor, "they tried to make me do something when I wanted to do something else". Resident #1 further stated that this had happened "about two</p>	F 221	<p>#4. Random observations of care being provided to residents identified as being restive to care will be done weekly x three months to monitor the effectiveness of the plan.</p> <p>#5. Results of the observation audits will be reported to the QA committee by the DNS or designee x 3 months with further frequency of audits being determined by the QA committee.</p> <p>#6. Corrective action will be complete by October 9, 2013.</p> <p>F221 POC accepted 10/17/13 Jhosmer RN Pmc</p>	
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F 221	Continued From page 2 days ago". At 2:45 PM on 9/19/13, the ADNS confirmed that LNA A used a drawsheet to restrain Resident #1 during the transfer on the evening of 9/15/13, and that LNA B witnessed LNA A holding the arms of Resident #1 during personal care. The ADNS further confirmed that LNA A had been suspended and re-educated, as well as reported to the Board of Nursing, related to the use of a draw sheet as a restraint.	F 221		
F 241 SS=G	<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: Based on Interviews and record reviews, the facility failed to assure that one of three residents in the sample (Resident #1) was treated by staff in a manner which maintained his/her dignity and respect in full recognition of his/her individuality.</p> <p>1. On 9/19/13, the surveyor reviewed the facility's internal investigation documents, written staff statements, and the medical record of Resident #1. Resident #1 (who is age 102 years) is assessed and care planned for urinary incontinence, anxiety, behaviors such as hitting, yelling, and throwing things, intermittent resistance to care, and forgetfulness related to advance age. Resident #1 is assessed and care planned for transfer by two staff using a stand and pivot technique.</p>	F 241	<p>Corrective Action</p> <p>F 241</p> <p>#1. Resident #1 has been assessed, no further injuries have been observed and the bruises are resolving. LNA's A, B & C are no longer employed by this Center.</p> <p>#2. All residents who exhibit resistance to care are at risk to be affected by this alleged deficient practice.</p> <p>#3. Staff have been re-educated regarding the policy on restraint use and as to alternative approaches to be utilized with residents exhibiting behaviors.</p>	

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F 241	<p>Continued From page 3</p> <p>Written evidence indicates that during the evening of 9/15/13, Resident #1 was agitated, hallucinatory, and resistive to care by nursing staff (as evidenced by yelling at staff and throwing things). Witness statements by the nurse on duty that evening, and three Licensed Nurse Assistants (LNAA, B, and C) who were on duty, indicate that Resident #1 had been incontinent of urine and had resisted multiple approaches and efforts to clean and change him/her during the evening shift. In a statement dated 9/16/13, the nurse related that s/he was unable to administer an as needed dose of an antianxiety medication (lorazepam) and instructed staff to allow Resident #1 to calm down.</p> <p>Written statements by LNA staff A, B, and C, as well as interview and re-education documentation by the Assistant Director of Nurses (ADNS), indicate that the three LNA staff elected to provide personal care to Resident #1, despite having been instructed by the nurse to let him/her calm down. Further, LNAA elected to wrap Resident #1 around the hands and feet with a draw sheet before moving him/her, allegedly to prevent harm during combativeness. The three LNA staff transferred Resident #1 from the wheelchair to the bed while wrapped in the draw sheet, then removed the sheet. At this time, according to written statements, LNAs A and C held the arms of Resident #1 while LNA C changed the wet brief and provided personal hygiene. On 9/19/13 at 9:45 AM, Resident #1 was observed to have purple bruising on the left and right wrist areas. When asked how this happened, Resident #1 stated to this surveyor, "they tried to make me do something when I wanted to do something else". Resident #1 further stated when asked twice, approximately 5</p>	F 241	<p>#4. Random observations of care being provided to residents identified as being restive to care will be done weekly x three months to monitor the effectiveness of the plan.</p> <p>#5. Results of the observation audits will be reported to the QA committee by the DNS or designee x 3 months with further frequency of audits being determined by the QA committee.</p> <p>#6. Corrective action will be complete by October 9, 2013.</p> <p>F241 POC accepted 10/17/13 JHosmerRNL/Amc</p>

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F 241	<p>Continued From page 4 minutes apart, that this had happened "about two days ago".</p> <p>During an interview on 9/19/13 at approximately 10:00 AM, LNA D (who worked on the unit from 10:30 PM 9/15/13 to 3:15 PM on 9/16/13) confirmed his/her written statement that LNA A had told him/her that "they had to manhandle [Resident #1] to get [him/her] changed and to bed". LNA D further stated that s/he had provided care to Resident #1 on 9/13/13 and that no bruises were present on the arms/wrists. LNA D also confirmed having provided care during the night shift and throughout the day 9/16/13, having first noticed bruising on the arms of Resident #1 while providing morning personal hygiene care on 9/16/13 at approximately 9:00 AM. At that time, LNA D reported to the day charge nurse both the bruises and the statement made by LNA A regarding "manhandling" Resident #1 on the evening of 9/15/13.</p> <p>On 9/19/13 at 11:45 AM, the Director of Social Services (who is also a Licensed Practical Nurse) confirmed having interviewed and observed Resident #1 on the morning of 9/16/13 immediately after being informed of the alleged "manhandling" on the evening of 9/15/13. S/he confirmed that both arms/wrists of Resident #1 had purpura (appearance of bleeding under the skin) such as is common with fragile skin in the elderly. During an interview at 2:45 PM on 9/19/13, the ADNS confirmed that LNAA used a drawsheet to restrain Resident #1 during the transfer on evening of 9/15/13, and that LNA B witnessed LNAA holding the arms of Resident #1 during personal care.</p>	F 241		