



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

September 23, 2009

James Beeler, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 27, 2009**. Please note that the returned form shows a correction to the exit date of the survey. Please post this document in a prominent place in your facility.

We will 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.

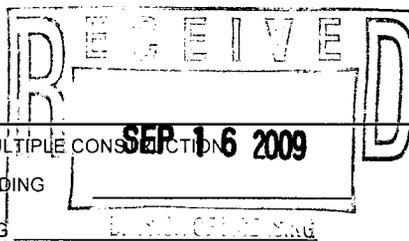
Sincerely,

Suzanne Leavitt, RN, MS
Licensing Chief

Enclosure



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



PRINTED: 09/09/2009
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 8/27/09 08/26/2009
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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 An unannounced annual recertification survey was completed by the Division of Licensing and Protection from 8/24/09 to 8/27/09.	F 000	F 246 Resident #121 did not have any adverse affects from this alleged deficient practice.	
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	Resident #121 was shaved and is being shaved as per his care plan.	
	This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility failed to meet the needs of 1 applicable resident (Resident #121) when they failed to provide daily grooming. Findings include:		In-service's will be done for LNA staff. A weekly audit of 10 random residents will be done for proper foot wear, proper facial grooming, and oral care times 3 months.	
F 253 SS=E	1. Per record review on 8/24/09 Resident #121's care plan states that the resident is to be shaved every morning. Per interview with family members on 8/25/09 at 5:00 PM, they stated that frequently the Resident is not shaved although they requested that the resident is shaved every morning. Per observation in the morning and afternoon on 8/26/09 Resident #121 was unshaven. Per interview with staff and confirmed by the Unit Nurse Manager on 8/26/09 at 3:10 PM, the resident was not shaved all day as requested.	F 253	Results of the audits will be reported to the Quality Improvement Committee monthly for the next 3 months by the Director of Nurses or designee. The Director of Nurses or designee will be responsible for compliance.	
	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.		The corrective action date 9/20/2009 P.O.C. Accepted. 9/23/09 Pamela Mata RN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/15/09
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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 253	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and confirmed through staff interview, the facility failed to assure a clean, sanitary environment in the laundry area. Findings include: 1. Per observation on 8/26 /09 at 11:45 AM during the environmental tour, the vent pipes from the dryers were covered with a layer of lint and dust. An air vent grate directly above the clean laundry folding table was also covered with lint and dust. Per interview on 8/26 /09 at 11:45 AM , the Head of Maintenance confirmed that the vent pipes and grate were dirty, were last cleaned per monthly schedule on 8/05/09, and would need to be cleaned more often to assure no build-up of lint and dust.	F 253	F253 No resident had any adverse affects from this alleged deficient practice. The laundry area will be cleaned every 2 weeks of dust and lint. Director of Housekeeping or designee will check for excess dust or lint build up once a week. The folding table under the air return vent will be moved from the air return vent.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	Results of the audits will be reported to the Quality Improvement Committee monthly for the next 3 months by the Director of Housekeeping or designee. The Director of Housekeeping or designee will be responsible for compliance. The corrective action date 9/20/2009 P.O.C. Accepted <i>9/23/09 Pamela Metcalf</i>	

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F 272	<p>Continued From page 2</p> <p>Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct a comprehensive assessment of 3 applicable residents (Residents #40, 9, 131). Findings include:</p> <p>1. Per record review, Resident #40's MDS assessment, conducted on 7/25/09, failed to document the resident's height. This was confirmed through interview with the Assistant Director of Nurses on the morning of 8/26/09. This is a resident that has a diagnosis of renal failure requiring a specialized diet, fluid restriction and ongoing weight monitoring.</p> <p>2. Per record review, Resident #9's MDS assessments from 7/15/09 (Admission), 7/18/09 (14 day) and 7/28/09 (30 day), failed to document a height for this resident. Per interview on 8/26/09 at 10:40 AM, the Unit Manager confirmed that the height of the resident was not recorded on the MDS assessments.</p>	F 272	<p>F 272</p> <p>Resident # 40, # 9 and #131 did not have any adverse affects from this alleged deficient practice.</p> <p>Audits of all new admissions will be check with-in 24 hours to ensure completion of height documentation. Before submittal of MDS the MDS coordinator will ensure height is on the form.</p> <p>Results of the audits will be reported to the Quality Improvement Committee monthly for the next 3 months by the Director of Nurses or designee.</p> <p>The Director of Nurses or designee will be responsible for compliance.</p> <p>The corrective action date 9/20/2009 P.O.C. Accepted. 9/23/09 Pamela Mata RN</p>	

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F 272	Continued From page 3 3. Per record review Resident #131, who was identified with impaired nutritional status and received nutritional replacement through a G-tube, had MDS assessments dated 5/4/09, 5/7/09, 5/17/09, and 7/24/09 that all lacked documentation of the resident's height. This was confirmed by the MDS Coordinator during interview on the morning of 8/25/09.	F 272		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to revise the comprehensive care plan to reflect the current status for 3 applicable residents (Residents #127,	F 280	F280 Resident # 127, #115 and #17 did not have any adverse affects from this alleged deficient practice. An LNA will attend weekly care plan meetings to ensure proper care plans are in place. The LNA care plan will be matched in detail to the care plan in the resident chart. Audits of care plans will be done to assure care plans reflect the current care needs of the resident. Random audits of care plans will be done once a week times 3 months by Director of Nurses or designee. Results of the audits will be reported to the Quality Improvement Committee monthly for the next 3 months by the Director of Nurses or designee.	

Per telephone call with Janice Jones DNS @ 9:30 am 9/22/09

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F 280	<p>Continued From page 4 17, 115). Findings include:</p> <p>1. Per record review on 8/25/09 for Resident #127, the care plan directed staff to toilet the resident before and after meals, before sleep, and that the resident wears incontinence briefs. Per observation on 8/26/09, staff did not toilet the resident before or after lunch. When the surveyor asked staff if the resident was on a toilet plan staff replied "he used to be on a toilet plan and he no longer wears incontinent pads." Per interview on 8/26/09 at 3:30 PM, the Unit Charge Nurse confirmed the care plan is not revised to reflect the current status and needs of the resident.</p> <p>2. Per interview and record review, the facility failed to revise the care plan to reflect the current needs around safety and falls prevention for Resident #17, who has a history of falls. Per record review, the current care plan for falls has a goal of "[Resident #17] should have no injuries related to falls," and an intervention that states "Assess that toileting plan is in place to prevent incontinence related falls." Per review of the care plan around incontinence and toileting, the only time that is identified to toilet the resident is after lunch. Per interview on 8/26/09 at 3:40 PM, the DNS (Director of Nursing Services) stated that the goals should include preventing falls, and the care plan should be updated to reflect his current toileting needs.</p> <p>3. Per interview and record review, the facility failed to revise the care plan around nutrition and assistance with meals for Resident #17. Per record review, the current plan of care directs staff to "supervise meals and fluids to assure no instances of aspiration," and to "provide extensive</p>	F 280	<p>The Director of Nurses or designee will be responsible for compliance.</p> <p>The corrective action date 9/20/2009</p> <p><i>P.O.C. Accepted 9/23/09 Pamela Moran RN</i></p>	

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F 280	<p>Continued From page 5</p> <p>assist of 1 for eating." Per interview, on 8/26/09 at 3:07 PM and 3:48 PM, a staff member and the DNS stated that Resident #17 needs only set-up assist for meals, and that he eats independently without supervision. During the interview on 8/26/09 at 3:48 PM, the DNS confirmed the care plan should be updated to reflect current needs.</p> <p>4. Per record review Resident #115's most current care plan had not been revised to reflect recently exhibited aggressive behavior towards staff and other residents. A nurse's note, dated 8/16/09 at 5:00 PM, stated that the resident "was found in another resident's room squeezing their (R) shoulder". On 8/17/09 (7-3 PM) the nurse's note stated that the resident was "anxious yelling at visitors...following other residents yelling at them." Another nurse's note, dated 8/19/09 (3-11 PM), revealed that the resident was very agitated and "more aggressive toward staff. Struck an LNA." Although there was clear evidence of increasingly aggressive behavior the resident's care plan was not revised to reflect the ongoing issue and on 8/22/09 at 11:30 AM another nurse's note identified that the resident "tried to push another resident out of his wheelchair". The care plan, which targeted Ineffective Individual Coping Mechanisms, initiated on 6/24/09, identified increased agitation and anxiety as an issue on 8/22/09, stated the goal was to decrease the agitation and aggressive behavior and included a note that stated "per MD new order for Trazodone and Ativan" as the only targeted intervention.</p> <p>Per interview, on the morning of 8/26/09, the</p>	F 280			

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F 280	Continued From page 6	F 280			
F 281 SS=D	<p>nurse Unit Manager confirmed that the care plan had not been revised to reflect the resident's current status and did not include any behavior monitoring interventions.</p> <p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to assure that care and services were provided in accordance with physician orders and professional standards of nursing practice for 3 applicable residents (Residents #9, #17, and #131). Findings include:</p> <p>1. Per record review nursing staff failed to administer tube feedings for Resident #131 in accordance with physician orders on 2 separate occasions. A physician order, dated 8/19/09, stated to increase the nutritional tube feeding to 93 ml per hour (via tube) over an 18 hour period; start at 4:00 PM and stop at 10:00 AM. Per observation, at 8:30 AM on 8/26/09, the resident's tube feeding was not infusing and had been disconnected. During interview, at that time, Nurse #1, who was responsible for administration of the tube feeding stated that, although s/he was aware of the order to continue the tube feeding at 93 ml/hour until 10:00 AM, the bag containing the nutritional supplement was empty so s/he had stopped the feeding. Nurse #1 further stated that s/he had also stopped the feeding at 8:30 AM on 8/20/09, one and a half hours before the recommended stop time, because the bag was empty at that time as well. In addition, a nurse's</p>	F 281	<p>F 281</p> <p>Resident #79, #17 and #131 did not have any adverse affects from this alleged deficient practice.</p> <p>On Resident # 131 the Tube Feeding will be monitored every hour for proper attachment and working condition place in the MAR.</p> <p>All nursing staff will be in-serviced on proper procedure of tube feeding equipment.</p> <p>Audits will be done once weekly for 3 months of the MAR completion on monitoring of tube feed.</p> <p>Resident #17 continues to receive nectar thickened liquids as recommended by Speech Therapy and ordered by MD on 7/1/09.</p>		

*→ All residents could be at risk. Random audits of diets will be done to ensure proper diets are met per pt. need.
(Per telephone conversation with Jamie Jones DNS @ 9:30 am 9/22/09.*

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F 281	<p>Continued From page 7</p> <p>note, dated 8/23/09 (7-3), stated "since 0530 in am found feeding apart feeding all over bed. LNA (Licensed Nursing Assistant) states it came apart throughout night also." Although an unknown amount of the feeding had been emptied into the resident's bed, there was no evidence that the amount lost had been estimated and replaced to assure the resident received the feeding in accordance with physician orders.</p> <p>During interview, on the morning of 8/27/09, the Nurse Unit Manager stated that the physician had been contacted on 8/26/09, and the resident received an additional 135 ml of nutritional tube feeding at approximately 10:30 that morning, to compensate for the amount lost when the feeding was disconnected an hour and a half early, at 8:30 AM. The unit manager also stated that s/he had not been aware that the nurse had stopped the G-tube feeding one and a half hours before the physician ordered stop time on 8/20/09. S/he agreed that, although an unknown amount of the nutritional feeding had been lost in the resident's bed on 8/23/09, there was no evidence that the amount lost had been estimated and replaced to assure the resident received the feeding in accordance with physician orders.</p> <p>2. Per interview and record review, Resident #17 is receiving altered consistency liquids with no basis for the change in diet order. Per record review, a physician's telephone order, written 7/1/09 by the Speech Therapist states, "Discontinue diet regular mechanical soft ground meats. Change diet to regular mechanical soft, no breads, nectar-thickened liquids." Per observation on 8/26/09, Resident #17 received nectar thick liquids with the noon meal. There was no evidence in the record of an evaluation completed or any adverse event that justified the</p>	F 281	<p>Resident #9 continues on Tamazepam and Ambien CR as ordered by MD after review for reduction was completed.</p> <p>Audits will be done on residents using sleeping aids times three months by the Director of Nurses or designee.</p> <p>The Director of Nurses or designee will be responsible for compliance.</p> <p>The corrective action date 9/20/2009</p> <p><i>P.O.C. Accepted 9/23/09 Pamela Mastar RN</i></p>		

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F 281	Continued From page 8 change in liquid consistency. During an interview on 8/27/09 at 9:50 AM, the speech therapist stated s/he "does not know why s/he would have done that," and confirmed that no evaluation was completed on 7/1/09. 3. Per record review on 8/25/09, Resident #9 had physician orders that included: Temazepam 15 mg. one cap PO at bedtime; and Ambien CR 12.5 mg. one tab PO at bedtime, both medications given for a diagnosis of insomnia. The pharmacist's admission review of medications dated 7/08/09 identified duplicate drug therapy for these 2 medications, and made a recommendation to discontinue one of the drugs. The physician wrote an undated order on the pharmacy recommendation sheet to discontinue the Ambien CR. Per review of the Medication Administration Record (MAR) for July and August, the resident continued to receive both medications on a nightly basis. The physician signed the plan of care on July 17, 2009 for July and August with the Ambien and Temazepam orders still active on the MAR. Per interview on 8/27/09 at 11:00 AM, the Unit Manager confirmed that the order was not transcribed to the MAR and the discontinued medication was still being administered to the resident.	F 281			
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS 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:	F 282	F 282 Resident #121 and #127 did not have any adverse affects from this alleged deficient practice. Resident #121 was shaved and is being shaved as per his care plan.		

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F 282	Continued From page 9 Based on record review, observation and interview, the facility failed to provide services in accordance with the written plan of care for 2 applicable residents in the sample (Residents #127 & #121) Findings include: 1. Per record review on 8/25/09, Resident #127's care plan directed staff to provide non-slip footwear such as non-skid socks [or shoes] at all times. On 8/26/09 at 10:46 Resident #127 was observed in the room with regular socks and a pair of sneakers under the television. At 1:15 PM the resident was observed walking in the hall with assistance with socks on. When interviewed at that time, the LNA stated "oh those are his regular socks...he needs non-skid socks" Per interview on 8/26/09 at 3:10 PM the Unit Charge Nurse confirmed the facility failed to implement the care plan for the resident by not providing non-slip footwear. 2. Per record review on 8/24/09, Resident #121's care plan states that the resident is to be shaved every morning. Per interview with family members on 8/25/09 at 5:00 PM, they stated that frequently the Resident is not shaved although they requested that the resident is shaved every morning. Per observation in the morning and afternoon on 8/26/09, Resident #121 was unshaven. Per interview with staff and confirmed by the Unit Nurse Manager on 8/26/09 at 3:10 PM, the resident was not shaved all day, as requested and care planned.	F 282	Resident #127 after taking a nap ambulated into the hall unassisted. He was immediately accompanied by nursing staff down the hall until appropriate foot was applied per care plan. In-service's will be done for LNA staff. A weekly audit of 10 random residents will be done for proper foot wear, proper facial grooming, and oral care times 3 months. Results of the audits will be reported to the Quality Improvement Committee monthly for the next 3 months by the Director of Nurses or designee. The Director of Nurses or designee will be responsible for compliance.		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	The corrective action date 9/20/2009 <i>P.O.C. Accepted 9/23/09 Pamela Montarini</i>		

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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 309	<p>Continued From page 10</p> <p>accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation and interview the facility failed to provide necessary care and services to maintain the resident's highest practicable level of well being in accordance with the comprehensive assessment and plan of care for 3 applicable residents in the survey sample (Residents #55, #127 & #12). Findings include:</p> <p>1. Based on observation and interview the facility failed to provide oral hygiene for Resident #55. Per resident interview on 8/27/09 at 10:25 AM the Resident stated "I've been here almost 2 years and I think I had my teeth brushed [or assisted] just a few times" Per interview on 8/27/09 at 10:30 AM the LNA stated that the teeth were not brushed with morning care. Per observation the resident's toothpaste and mouthwash were dated 7/21/08 in which the tube was slightly used and the bottle unopened. Per interview on 8/27/09 at 11:00 AM the DNS (Director of Nursing) confirmed that the resident is reliable and teeth are to be brushed twice daily with morning and evening care.</p> <p>2. Based on observation , record review and interview staff failed to provide non-slip footwear for Resident #127, who has a history of falls. Per the MDS (Minimum Data Set) dated 6/24/09, Resident #127 had falls within the last 30 days and limitations with strength and balance. The care plan for falls directed staff to provide non-skid footwear and implement falls prevention</p>	F 309	<p>F 309</p> <p>Resident # 55, #12 and #127 did not have any adverse affects from this alleged deficient practice.</p> <p>In-services will be done for LNA staff. A weekly audit of 10 random residents will be done for completion of oral care times 3 months.</p> <p>Resident #127 after taking a nap ambulated into the hall unassisted. He was immediate accompanied by nursing staff down the hall until appropriate foot was applied per care plan.</p> <p>In-service's will be done for LNA staff. A weekly audit of 10 random residents will be done for proper foot wear, proper facial grooming, and oral care times 3 months.</p> <p>Results of the audits will be reported to the Quality Improvement Committee monthly for the next 3</p>		

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F 309	Continued From page 11 measures. On 8/26/09 at 10:46 AM, Resident #127 was observed wandering in the room with regular socks on and a pair of sneakers under the television. At 1:15 PM on the same day, the resident was observed walking in the hall with assistance with socks on. When interviewed at that time, the LNA stated "oh those are his regular socks...he needs non-skid socks" Per interview on 8/26/09 at 3:10 PM the Unit Charge Nurse confirmed the facility failed to provide the services required to ensure that the resident is able to walk safely. 3. Per resident and staff interview, the facility failed to provide and/or assist Resident #12 with mouth care on a regular basis. Per resident interview on 8/26/09 at 2:10 PM, the Resident states that s/he cannot remember the last time that s/he was provided with mouth care or assisted with mouth care. States that "a long time ago" staff used to give her swabs to clean her own mouth or give her mouthwash, but restated that that has not happened in a long time. Per interview with the LNA responsible for care on 8/26/09 at 2:15 PM, s/he stated that she did not perform mouth care or assist resident in doing mouth care this morning during AM care.	F 309	months by the Director of Nurses or designee. The Director of Nurses or designee will be responsible for compliance. The corrective action date 9/20/2009 <i>P.D.C Accepted 9/23/09 JounelaMortaru</i>		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	F 325 Resident #131 did not have any adverse affects from this alleged deficient practice his weight is stable. Hourly tube feeding checks where entered on the MAR to monitor for proper attachment and working condition.		

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F 325	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide nutritional care and services consistent with the comprehensive assessment and failed to assure that acceptable parameters of nutritional status were maintained for 1 applicable resident in the sample (Resident #131). Findings include:</p> <p>Per observation, staff interview and record review nursing staff failed to consistently administer tube feedings for nutrition replacement in accordance with physician orders; failed to act on a faulty equipment issue related to repeated tube leakage; failed to consistently monitor the resident's enteral fluid intake, and failed to follow consistent practice for obtaining weights for Resident #131, who suffered an unplanned 12 pound weight loss.</p> <p>Per record review Resident #131, whose medical conditions included dysphagia (difficulty swallowing), was admitted to the facility on 4/27/09 with an NPO (nothing by mouth) status and received nutrition replacement via G-tube (gastrostomy tube). Although there was no assessment of the resident's height or calculated BMI (Body Mass Index) the nutritional needs were assessed based on the admission weight of 239.6 pounds, the resident was started on foods and fluids po (by mouth) and the daily G-tube feedings were slowly decreased. On 8/10/09 an RD (Registered Dietician) progress note identified that the resident's weight was 230.6 pounds, and</p>	F 325	<p>In-services will be done for nursing staff on proper monitoring of tube feeding equipment.</p> <p>Audits of residents on continuous tube feedings will be done once weekly times 3 month by Director of Nursing or designee.</p> <p>The Director of Nurses or designee will be responsible for compliance.</p> <p>The corrective action date 9/20/2009</p> <p><i>P.O.C. Accepted. 9/23/09 Pamela Matarin</i></p>	

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F 325	<p>Continued From page 13</p> <p>that there had been a weight loss of 3.4 pounds in a week, and 9 pounds in 3 months. The note also indicated that the resident had recently been ill, had poor po meal intakes and had developed an open area on the left heel. A subsequent RD progress note, dated 8/19/09, revealed that the resident's weight had dropped to 228.7 pounds, and the po intake continued to be poor and a recommendation was made by the RD to increase the G-tube feedings. A physician order, dated 8/19/09, stated to increase the nutritional tube feeding to 93 ml per hour (via tube) over an 18 hour period, starting at 4:00 PM and stopping at 10:00 AM. The most recent weight, recorded on 8/20/09, was 227 pounds.</p> <p>A nurse's note, dated 8/21/09 (6:30- 11:00 PM), indicated that the tubing for the G-tube feeding had disconnected twice on that date and a subsequent nurse's note, dated 8/23/09 (7-3), stated "since 0530 in am found feeding apart feeding all over bed. LNA (Licensed Nursing Assistant) states it came apart throughout night also." Although an unknown amount of the feeding had been lost in the resident's bed, there was no evidence that the amount lost had been estimated and replaced to assure the resident received the recommended amount. The documentation also lacked evidence of any action to determine the cause of the repeated disconnection of the tubing or plan to resolve the ongoing issue. Review of the Total Intake and Output Records for the month of August 2009 revealed a lack of documentation of the total amount of enteral feeding on 24 out of 60 shifts making it difficult to assure the resident's nutritional and fluid intake were adequate.</p> <p>Per observation, at 8:30 AM on 8/26/09, the</p>	F 325		
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F 325	<p>Continued From page 14</p> <p>resident's G-tube feeding was not infusing. During interview, at that time, Nurse #1, who was responsible for administration of the tube feeding stated that, although s/he was aware of the order to continue the tube feeding at 93 ml/hour until 10:00 AM, the bag containing the nutritional supplement was empty so s/he had stopped the feeding. Nurse #1 further stated that s/he had also stopped the feeding at 8:30 AM on 8/20/09, one and a half hours before the physician ordered stop time, because the bag was empty at that time as well. In addition, per observation, at 8:30 on the morning of 8/27/09, during the administration of the tube feeding the tubing again became disconnected. Nurse #1 stated, at that time, that the tube had been disconnected "for quite a while, there was a large puddle of fluid on the floor and (resident's) bed was soaked."</p> <p>During interview, at 2:30 PM on 8/26/09, the RD stated that, although s/he had been aware that there had been an issue with the tubing for the G-tube leaking, s/he had not been aware that staff had stopped the feedings one and a half hours early on at least 2 occasions. The RD also confirmed the lack of consistent monitoring of enteral intake by staff and agreed that it is difficult to monitor the enteral intake accurately when the I & O form is not completed by staff.</p> <p>Per interview, on the morning of 8/27/09, and although the nurse Unit Manager had obtained physician order to replace the approximate amount of nutritional supplement lost in each of the observed situations on 8/26 and 8/27/09, s/he stated that s/he had not been aware that Nurse #1 had not administered the G-tube feeding in accordance with physician orders on 8/20/09. S/he also stated that s/he had been unaware of</p>	F 325		

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F 325	Continued From page 15 the issue with the G-tube leaking until the morning of 8/27/09. The Nurse Manager confirmed that there was no evidence that the resident had received the G-tube feeding in accordance with physician orders on 8/23/09 when the tubing disconnected and the nutritional supplement was emptied into the resident's bed, and s/he further confirmed the lack of consistent monitoring of enteral fluid intake through the month of August. Per telephone interview, on the afternoon of 8/27/09, the DNS (Director of Nursing Services) stated that the resident had been weighed earlier that morning and the weight had been recorded at less than 227 pounds. S/he further stated that the resident had been re-weighed in the afternoon and the weight was 227.6 pounds, an actual gain of 0.6 pounds from the last obtained weight on 8/20/09. The DNS stated that, although the care plan did not reflect the intervention, the resident should have been weighed with a helmet in place and it appeared staff had not been consistent in that practice, leading to inaccuracy of weights.	F 325		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	F 328 Resident #131 did not have any adverse affects from this alleged deficient practice his weight is stable. Hourly tube feeding checks were entered on the MAR to monitor for proper attachment and working condition.	

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F 328	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to assure that proper treatment and care were provided for 1 resident in the applicable sample receiving enteral feedings (Resident #131). Findings include:</p> <p>Per observation, staff interview and record review nursing staff failed to consistently administer tube feedings for nutrition replacement in accordance with physician orders; failed to act on a faulty equipment issue related to repeated tube leakage and failed to consistently monitor the enteral fluid intake for Resident #131, who sustained an unplanned 12 pound weight loss.</p> <p>Per record review Resident #131, whose medical conditions included dysphagia (difficulty swallowing), was admitted to the facility on 4/27/09 with an NPO (nothing by mouth) status and received nutrition replacement via G-tube (gastrostomy tube). A decline in the resident's condition and subsequent weight loss resulted in a physician order, dated 8/19/09, which stated to administer Promote with Fiber (a liquid nutritional resource) at 93 ml per hour (via G-tube) over an 18 hour period, starting at 4:00 PM and stopping at 10:00 AM.</p> <p>A nurse's note, dated 8/21/09 (6:30- 11:00 PM), revealed that the tubing for the G-tube feeding had disconnected twice on that date, and a subsequent nurse's note, dated 8/23/09 (7-3), stated "since 0530 in am found feeding apart feeding all over bed. LNA states it came apart throughout night also." Although an unknown</p>	F 328	<p>In-services will be done for nursing staff on proper monitoring of tube feeding equipment.</p> <p>Audits of residents on continuous tube feedings will be done once weekly times 3 month by Director of Nursing or designee.</p> <p>The Director of Nurses or designee will be responsible for compliance.</p> <p>The corrective action date 9/20/2009</p> <p><i>P.O.C. Accepted. 9/23/09 Pamela Metcalf</i></p>	
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F 328	<p>Continued From page 17</p> <p>amount of the nutritional fluid had been lost in the resident's bed, there was no evidence that the amount lost had been estimated and replaced to assure the resident received the nutritional feeding in accordance with physician orders. The documentation also lacked evidence of any action to determine the cause of the repeated disconnection of the tubing or plan to resolve the ongoing issue. Review of the Total Intake and Output Records for the month of August 2009 revealed a lack of documentation of the total amount of enteral feeding on 24 out of 60 shifts making it difficult to assure the resident's nutritional and fluid intake were adequate.</p> <p>Per observation, at 8:30 AM on 8/26/09, the resident's G-tube feeding was not infusing. During interview, at that time, Nurse #1, who was responsible for administration of the tube feeding stated that, although s/he was aware of the order to continue the tube feeding at 93 ml/hour until 10:00 AM, the bag containing the nutritional supplement was empty so s/he had stopped the feeding. Nurse #1 further stated that s/he had also stopped the feeding at 8:30 AM on 8/20/09, one and a half hours before the physician ordered stop time, because the bag was empty at that time as well. In addition, per observation, at 8:30 on the morning of 8/27/09, during the administration of the tube feeding the tubing again became disconnected. Nurse #1 stated, at that time, that the tube had been disconnected "for quite a while, there was a large puddle of fluid on the floor and (resident's) bed was soaked."</p> <p>During interview, at 2:30 pm on 8/26/09, the RD stated that, although s/he had been aware that there had been an issue with the G-tube leaking during feedings, s/he had not been aware that</p>	F 328		
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F 328	Continued From page 18 staff had stopped the feedings one and a half hours early on at least 2 occasions. The RD also confirmed the lack of consistent monitoring of enteral intake by staff and agreed that it is difficult to monitor the nutritional intake accurately when the I & O form is not completed by staff. Per interview, on the morning of 8/27/09, and although the nurse Unit Manager had obtained physician order to replace the approximate amount of nutritional supplement lost in each of the observed situations on 8/26 and 8/27/09, s/he stated that s/he had not been aware that Nurse #1 had not administered the G-tube feeding in accordance with physician orders on 8/20/09. S/he also stated that s/he had been unaware of the issue with the G-tube leaking until the morning of 8/27/09. The Nurse Manager confirmed that there was no evidence that the resident had received the G-tube feeding in accordance with physician orders on 8/23/09 when the tubing disconnected and the nutritional supplement was emptied into the resident's bed, and s/he further confirmed the lack of consistent monitoring of enteral fluid intake through the month of August.	F 328		
F 329 SS=E	483.25(I) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	F 329 Resident #9, #40 and #115 did not have any adverse affects from this alleged deficient practice. Nursing staff on the 11-7 shift will do 24 hour chart reviews on all new orders. The Director of Nurses or designee will do a weekly audit for 3 months to ensure all orders are transcribed correctly.	

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F 329	<p>Continued From page 19</p> <p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure 3 applicable residents were free from unnecessary drugs (Residents #40, 115, 9). Findings include:</p> <p>1. Per record review conducted on 8/27/09, on 7/25/09, the physician increased Resident #40's Lantus Insulin from 20 units to 24 units at bedtime. Nursing staff failed to assure this medication change was transcribed onto the August Medication Administration Record (MAR) and subsequently the resident was administered the incorrect dose of Lantus from August 1 through August 26; (26 days). This was confirmed through interview with the Assistant Director of Nurses at 8:45 AM on 8/27/09.</p> <p>2. Per record review, on 8/26/09, Resident #115 had physician orders for 2 separate drugs for which there was no adequate indication for use. A physician order, dated 8/22/09, directed staff to administer Ativan (antianxiety) 0.5 mg orally every</p>	F 329	<p>Resident #9 continues on Tamazepam and Ambien CR as ordered by MD after review for reduction was completed.</p> <p>Audits will be done on residents using sleeping aids times three months by the Director of Nurses or designee.</p> <p>Resident #115 doctor order for PRN Ativan and Trazadone was discontinued previously 8/26/09.</p> <p>The Director of Nurses or designee will be responsible for compliance.</p> <p>The corrective action date 9/20/2009</p> <p><i>P.O.C. Accepted 9/23/09 Pamela Montano</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 8/27/09 <i>af</i> 08/26/2009
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 329	<p>Continued From page 20</p> <p>4 hours as needed for severe agitation. There were no targeted behaviors identified to monitor effectiveness of the drug once it had been administered. The same physician order instructed staff to administer "Trazodone (an antidepressant sometimes used to treat anxiety) 25 mg orally three times daily as needed. Hold for excess sedation" and did not identify an indication for its use. When questioned by the surveyor, on the morning of 8/26/09, regarding an indication for use of the Trazodone, Nurse #1, who was responsible for administering medications on that date, stated "I don't know what it would be given for".</p> <p>During interview, on the morning of 8/26/09, the nurse Unit Manager confirmed that there was no indication for the use of PRN (as needed) Trazodone and no targeted behaviors identified for use of either the Ativan or the Trazodone.</p> <p>3. Per record review on 8/25/09, Resident #9 had physician orders that included: Temazepam 15 mg. one cap PO at bedtime; and Ambien CR 12.5 mg. one tab PO at bedtime, both medications given for a diagnosis of insomnia. The pharmacist's admission review of medications dated 7/08/09 identified duplicate drug therapy for these 2 medications, and made a recommendation to discontinue one of the drugs. The physician wrote an undated order on the pharmacist consult sheet to discontinue the Ambien CR. Per review of the Medication Administration Record (MAR) for July and August, the resident continued to receive both medications on a nightly basis. Per interview on 8/27/09 at 11:00 AM, the Unit Manager confirmed that the order was probably written on 7/17/09 when the physician was last in the building, was</p>	F 329		

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F 329	Continued From page 21 not transcribed to the MAR, and the discontinued medication was still being administered to the resident.	F 329		
F 386 SS=D	<p>483.40(b) PHYSICIAN VISITS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the physician failed to review the total program of care at each visit for 1 applicable resident in the sample (Resident #9). Findings include:</p> <p>1. Per record review on 8/25/09, Resident #9 had physician orders that included: Temazepam 15 mg. one cap PO at bedtime; and Ambien CR 12.5 mg. one tab PO at bedtime, both medications given for a diagnosis of insomnia. The pharmacist's admission review of medications dated 7/08/09 identified duplicate drug therapy for theses 2 medications, and made a recommendation to discontinue one of the drugs. The physician wrote an order with no date recorded that discontinued the Ambien CR. Per review of the Medication Administration Record (MAR) for July and August, the resident continued to receive both medications on a nightly basis. The physician signed the plan of care on July 17, 2009 for July and August with the Ambien and</p>	F 386	<p>F 386</p> <p>Resident #9 did not have any adverse affects from this alleged deficient practice.</p> <p>Resident #9 continues on Tamazepam and Ambien CR as ordered by MD after review for reduction was completed.</p> <p>Audits will be done on residents using sleeping aids times three months by the Director of Nurses or designee.</p> <p>The Director of Nurses or designee will be responsible for compliance.</p> <p>The corrective action date 9/20/2009</p> <p><i>P.O.C. Accepted 9/23/09 Pamela Motta RN</i></p>	

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F 428	Continued From page 23 Administration Record (MAR) for July and August, the resident continued to receive both medications on a nightly basis. Per interview on 8/27/09 at 11:00 AM, the Unit Manager confirmed that the order had not been transcribed to the MAR, and the discontinued medication was still being administered to the resident.	F 428			
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	F 431 No resident had any adverse affects from this alleged deficient practice. All 11-7 nursing staff will be re-educated on interventions for abnormal temperatures. DNS or designee will monitor temperature logs once weekly for 3 months to insure logs are being maintained and refrigerator has appropriate temperature. The Director of Nurses or designee will be responsible for compliance. The corrective action date 9/20/2009 P.O.C. Accepted 9/23/09 Pamela M. R.N.		

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F 431	<p>Continued From page 24 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store drugs under proper temperature controls in the Wing 1 medication refrigerator. Findings include:</p> <p>Per review of medication refrigerator temperature logs from 12/08 to present, the facility failed to store drugs in the recommended temperature range stated on the medications that are stored in that refrigerator. Refrigerator logs recorded multiple temperatures below 36 degrees F (Fahrenheit) over several months. For example, in December 2008, 23 of the 27 recorded temperatures were below 36 F, with 12 temperatures below the freezing temperature of 32 F, and in the current month of August 2009, there were 3 consecutive temperatures of 32 F. Per observation on 8/27/09 at 10:20 AM, medications stored in the refrigerator include: Novolog flex pen (states on box avoid freezing), tuberculin (Aplisol) injection, Humalog insulin, Novolin 70/30, Novolin R insulin (which states on label do not freeze), Lantus insulin (which states on vial do not freeze), Engerix (which states on vial to store at 36 to 46 F and states "do not freeze."), multiple Pneumovax injections (which state on vials store at 36-46 F), and Lantus Solostar (states on box store refrigerated at 36-46 F. Do not freeze. Discard if frozen.) Per interview on 8/27/09 at 10:45 AM, the Assistant Director of Nurses viewed the temperature logs and confirmed multiple temperatures were below or at freezing and/or outside of the recommended</p>	F 431		
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F 431 F 469 SS=E	<p>Continued From page 25 range stated on the medication packaging.</p> <p>483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an effective pest control program so that the facility is free of pests. Findings include:</p> <ol style="list-style-type: none"> Per observation by all surveyors throughout the 4 days of survey, numerous flies were present in the resident areas of the facility. Per resident interview on 8/24/09 at 3:52 PM, Resident #12 complained about flies in room and stated "they [staff] just killed 2 of them." During the interview, this surveyor witnessed flies in the room and saw at least 1 fly land on the resident's body. Per resident interview on the morning of 8/26/09, Resident #139 stated, "there have been a lot of flies in here." During observation of the breakfast meal on the morning of 8/27/09, several flies were noted on Resident #139's plate of food. 	F 431 F 469	<p>Tag F 469</p> <p>No residents were harmed by this alleged deficiency.</p> <p>The facility has a contract with Stowe Pest Control, and they have been (and will continue) to come into the facility and treat for various pests twice a month. The facility also maintains two electronic "bug zappers", and those will continue to be operated year round.</p> <p>The flies are a seasonal problem, and they were not present in the facility the week before survey, and they were gone from the facility the week after the survey team was in the building. Thus, there are no further actions that can be taken or need to be taken regarding this problem.</p> <p>Administrator will monitor the situation, and will report to the Q.A. Committee times three months.</p> <p>Plan of Correction completion date: September 18, 2009.</p> <p><i>P.O.C. Accepted. 9/23/09 Pamela Montanari</i></p>	
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