

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

October 20, 2011

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

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 30, 2011**. 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

OCT 18 2011

PRINTED: 10/12/2011
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 09/30/2011
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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 F 223 SS=G	<p>INITIAL COMMENTS</p> <p>An unannounced, on-site complaint investigation was completed on 9/30/11 by the Division of Licensing and Protection. The following are regulatory findings.</p> <p>483.13(b), 483.13(b)(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 record reviews and interviews, the nurse failed to assure Resident #1's right to be free from involuntary seclusion when a nurse placed the resident (who is wheelchair-bound and has severe dementia) alone in the shower room with the door closed, lights off, and without access to a call system, for an unspecified length of time during the night shift of 09/23-24/11. Findings include:</p> <p>1. During an interview at 10:30 AM on 09/30/11, the Administrator provided copies of the signed, written statements and interview notes of 09/28/11, as conducted by the Director of Nursing (DNS) with the charge nurse and two Licensed Nurse Assistants (LNA) who were on duty during the night shift from 09/23/11 into 09/24/11. Per incident record review, LNA A wrote that on the night of 09/23/11, the nurse placed Resident #1</p>	F 000 F 223	<p>F 223</p> <p>Resident # 1 was and is at baseline both physically and cognitively following this violation of resident right to be free from seclusion.</p> <p>Resident # 1 has shown no change in condition related to this violation. Resident # 1 has been and continues to be monitored by both nursing and social services for any change in condition.</p> <p>Any resident in the facility has the potential to be affected by this violation.</p> <p>The Nurse and 2 nursing assistants involved in this violation have been terminated from the facility and appropriate licensing boards have been notified.</p> <p>All staff will be re-educated on abuse/neglect guidelines and mandated reporting guidelines.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/17/2011
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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 223	<p>Continued From page 1</p> <p>(who had been yelling) in the shower room with the door closed for an unspecified length of time. LNA B wrote that "on Friday night, the nurse put [Resident #1] into the shower room because [s/he] wouldn't settle down". There was no written statement from the charge nurse; however, the DNS (Director of Nursing Services) documented a phone conversation with the nurse on 09/28/11 where the nurse answered " yes " when the DNS asked if s/he had placed Resident #1 in the shower room. Per record review, the nurse also stated having "tried everything else".</p> <p>Per Medication Administration Record (MAR) review, the nurse had administered 1 mg (milligram) Lorazepam (a medication ordered for as needed use to address agitation) on 09/23/11 at 2345 hours (11:45 PM) with no effect. At 0100 (1:00 AM) on 09/24/11, the nurse administered 650 mg acetaminophen (an as needed medication for pain) with no effect. At 0200 (2:00 AM) on 09/24/11, the nurse administered 0.5 mg Haldol (a medication ordered for as needed use to address severe agitation) with no effect. Per review of the behavioral sheets, documentation indicated that Resident #1 had three episodes of agitation and yelling out during the night shift on 09/24/11. On 09/30/11 at 2:00 PM, the nurse unit manager confirmed that the medical record reflected three pharmacological interventions for agitation and yelling during the night shift of 09/24/11. Per review of a signed written statement, LNA C wrote that at 5:15 AM on the morning of 09/24/11, s/he "went into the shower room and found [Resident #1] sitting in the dark. The shower room door was closed".</p> <p>During an interview at 1:15 PM on 09/30/11, LNA</p>	F 223	<p>Random audits will be done weekly x 90 days.</p> <p>The results of all audits will be reported to the facility QA committee for review for 90 days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: October 21, 2011</p> <p><i>F223 POC accepted 10/19/11 JHsmerrn/AMctarn</i></p>		

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F 223	Continued From page 2 C stated that as part of his/her preparation for the 06:00 AM day shift, s/he always goes first into the shower room to check the shower list for the day. LNA C further stated that on the morning of 09/24/11 at 05:15 AM, s/he opened the door and turned on the light and discovered Resident #1 asleep in the wheelchair in the back of the shower room. LNA C indicated that there was no call system available to resident. LNA C also stated that s/he wheeled Resident #1 out to the nurse's station and said to the charge nurse, "Look who I found in the shower room", and that the charge nurse stated, "Oh, I forgot about her being in there". On 09/30/11 at 1:45 PM, LNA C and this surveyor observed the shower room together and stood in the back of the room with the lights off. There was a very small amount of light visible through a slit window in the upper left panel of the door. At that time, LNA C confirmed that this was the environment in which s/he discovered Resident #1 at 5:15 AM on 09/24/11.	F 223		
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and observations, the facility staff failed to provide care to Resident #1 (who is wheelchair-bound and has severe dementia) in a manner and in an environment that promoted or maintained the resident's dignity when they placed and	F 241	F 241 Resident # 1 was and is at baseline both physically and cognitively following this violation of resident dignity and respect. Resident # 1 has shown no change in condition related to this violation.	

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F 241	<p>Continued From page 3</p> <p>maintained the resident alone in a dark shower room for an unspecified length of time during the night shift of 09/23-24/11. Findings include:</p> <p>1. During an interview at 10:30 AM on 09/30/11, the Administrator provided copies of the signed, written statements and interview notes of 09/28/11, as conducted by the Director of Nursing (DNS) with the charge nurse and two LNAs who were on duty during the night shift from 09/23/11 into 09/24/11 on wing 1. Per incident record review, LNA A wrote that on the night of 09/23/11, the nurse placed Resident #1 (who had been yelling) in the shower room with the door closed for an unspecified length of time. LNA B wrote that "on Friday night, the nurse put [Resident #1] into the shower room because [s/he] wouldn't settle down". There was no written statement from the nurse; however, the DNS documented a phone conversation with the nurse on 09/28/11 where the nurse answered "yes" when the DNS asked if s/he had placed Resident #1 in the shower room.</p> <p>Per review of a signed written statement, LNA C wrote that at 5:15 AM on the morning of 09/24/11, s/he "went into the shower room and found [Resident #1] sitting in the dark. The shower room door was closed". During an interview at 1:15 PM on 09/30/11, LNA C stated that as part of his/her preparation for the 06:00 AM day shift, s/he always goes first into the shower room to check the shower list for the day. LNA C further stated that on the morning of 09/24/11 at 05:15 AM, s/he opened the door and turned on the light and discovered Resident #1 asleep in the wheelchair in the back of the shower room. LNA C indicated that there was no call system</p>	F 241	<p>Resident # 1 has been and continues to be monitored by both nursing and social services for any change in condition.</p> <p>Any resident in the facility has the potential to be affected by this violation.</p> <p>The Nurse and 2 nursing assistants involved in this violation have been terminated from the facility and appropriate licensing boards have been notified.</p> <p>All staff will be re-educated on dignity and respect guidelines .</p> <p>Random audits will be done weekly x 90 days.</p> <p>The results of all audits will be reported to the facility QA committee for review for 90 days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date: October 21, 2011</p> <p><i>F241 POC accepted 10/19/11 JHtsmer RN/A. Mota RN</i></p>	
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F 241 Continued From page 4 available to the resident. LNA C also stated that s/he wheeled Resident #1 out to the nurse's station and said to the charge nurse, "Look who I found in the shower room", and that the nurse stated, "Oh, I forgot about her being in there". On 09/30/11 at 1:45 PM, LNA C and this surveyor observed the shower room together and stood in the back of the room with the lights off. There was a very small amount of light visible through a slit window in the upper left panel of the door. At that time, LNA C confirmed that this was the environment in which s/he discovered Resident #1 at 5:15 AM on 09/24/11.

F 241

F 282 SS=G 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

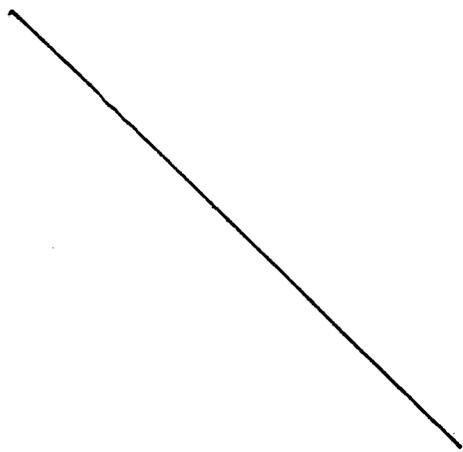
F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on record reviews and interviews, the facility staff failed to correctly implement the written, multidisciplinary plan of care for Resident #1 (who is at high risk for falls, is wheelchair/bed bound, and has severe dementia). Findings include:

1. Per medical record review, the written plan of care for Resident #1 includes specific measures to: "maintain safe environment; reassure of safety if delusional thinking occurs; be sure the resident is within sight of staff when out of bed in wheelchair; maintain safety when behavior escalates and attempt to reapproach; offer



F 282

Resident # 1 was and is at baseline both physically and cognitively following this violation of failure to provide care in accordance with the resident's written plan of care.

Resident # 1 has shown no change in condition related to this violation.

Resident # 1 has been and continues to be monitored by both nursing and social services for any change in condition.

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F 282	Continued From page 5 non-pharmaceutical approach to sleep assist, back massage, music, reading, tv, etc." During an interview at 10:30 AM on 09/30/11, the Administrator provided copies of the signed, written statements and interview notes of 09/28/11, as conducted by the Director of Nursing (DNS) with the nurse and two LNAs who were on duty during the night shift from 09/23/11 into 09/24/11. Per incident record review, LNA A wrote that on the night of 09/23/11, the nurse placed Resident #1 (who had been yelling) in the shower room with the door closed for an unspecified length of time. LNA B wrote that "on Friday night, the nurse put [Resident #1] into the shower room because s/he wouldn't settle down". The DNS documented a phone conversation with the nurse on 09/28/11 where the nurse answered "yes" when the DNS asked if s/he had placed Resident #1 in the shower room. Per review of a signed written statement, LNA C wrote that at 5:15 AM on the morning of 09/24/11, s/he "went into the shower room and found [Resident #1] sitting in the dark asleep in the wheelchair. The shower room door was closed and there was no call system". During an interview at 1:15 PM on 09/30/11, LNA C confirmed that on the morning of 09/24/11 at 05:15 AM, s/he opened the door and turned on the light and discovered Resident #1 asleep in the wheelchair in the back of the shower room. LNA C indicated that there was no call system available to the resident. During an interview on 09/30/11 at 4:00 PM, the nurse unit manager confirmed that on the night shift of 09/24/11, the three staff on duty had not implemented the written plan of care for safety, reassurance, and non-pharmaceutical approaches when they left Resident #1 alone and	F 282	Any resident in the facility has the potential to be affected by this violation. The Nurse and 2 nursing assistants involved in this violation have been terminated from the facility and appropriate licensing boards have been notified. All staff will be re-educated on following resident's written plan of care. Random audits will be done weekly x 90 days. The results of all audits will be reported to the facility QA committee for review for 90 days. The DNS/designee will be responsible for compliance. Corrective Action date: October 21, 2011. <i>F282 POC accepted 10/19/11 JHosmerRN/PMCotRN</i>	

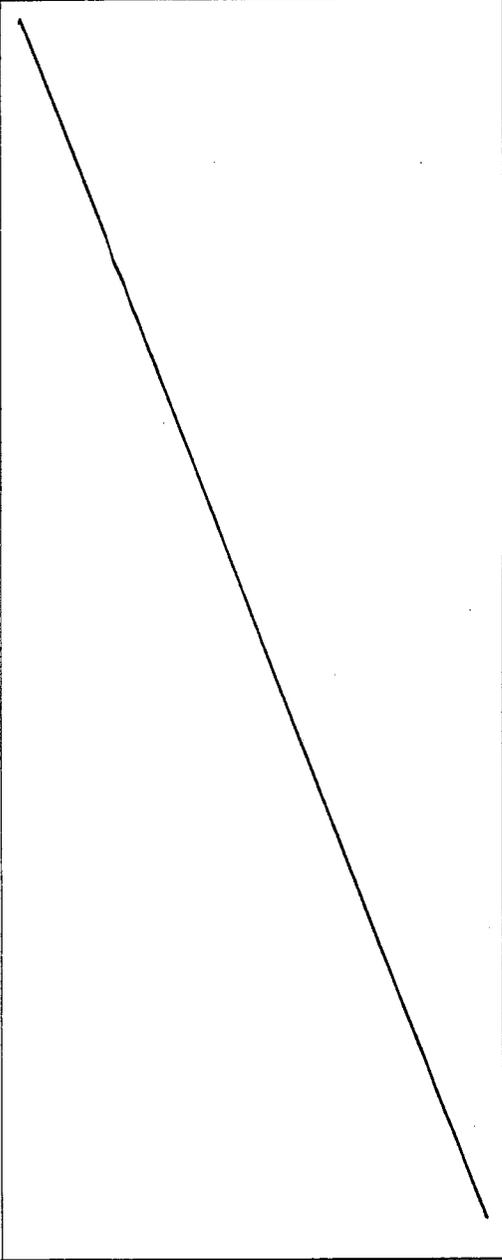
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F 282	Continued From page 6 unsupervised in the dark shower room for an unspecified length of time.	F 282		
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