

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

December 6, 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 **November 13, 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



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

RECEIVED PRINTED: 11/21/2013  
Division of 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 _____	DEC -2 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED  C 11/13/2013
--	--	--	---------------------------------------	---

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	F 000		
F 157 SS=D	<p>The Division of Licensing and Protection conducted an investigation of complaints and facility self-reports on 11/12/13 and 11/13/13. Regulatory violations were cited as a result. Immediate Jeopardy to the health and safety of residents was identified, which also resulted in a determination of Substandard Quality of Care.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p>	F 157	<p>F 157 Corrective Action</p> <ol style="list-style-type: none"> <li>1. Resident #3 did not have any negative outcome related to this alleged deficient practice.</li> <li>2. Residents who reside in the center have the potential to be affected by this alleged deficient practice.</li> <li>3. Notification of the policy for surveillance equipment will be sent to all residents and/or their responsible parties.</li> <li>4. Monitoring for the ongoing compliance with this practice will occur with any policy changes</li> <li>5. Any policy changes will be brought to the QA committee x3 months. After 3 months the QA committee will determine further action.</li> <li>6. The Executive Director will be responsible for monitoring the compliance of this program.</li> <li>7. Corrective action will be complete by December 1, 2013</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maria C. Monte</i>	TITLE Executive Director	(X6) DATE 11-27-13
--	-----------------------------	-----------------------

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

PMC

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

PRINTED: 11/21/2013  
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 11/13/2013
--	--	--	---

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 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 clinical record review and interviews, for 1 of 6 sampled residents, (Resident #3) the facility failed to provide written notification to the resident and the resident's legal representative when there is a change in resident rights policy. The findings include:</p> <p>Resident #3 was admitted on 6/2/09 with diagnoses to include Lewey Body Dementia, Depression and Heart Failure. Per interview, Resident #3's DPOA (Durable Power of Attorney) has been permitted to audio tape care plan meetings for the past one and one-half years. This initiative was permitted by past administration for the purpose of sharing information with Resident #3 in a non threatening environment, with noise control and no time constraints.</p> <p>Per interview on 11/13/13 @10:07 AM with the Social Service Director and the Nursing Home Administrator (NHA), confirmation was made that Resident #3's DPOA was informed of the Surveillance policy during a meeting with Vice President of Operations and NHA. During the meeting the DPOA was informed the practice of audio taping was no longer allowed under current administration. Per medical record review, there is no evidence in the Social Service Progress Notes or in the Resident's Care Plan indicating that audio taping is no longer allowed for the purposes of sharing information with Resident #3.</p>	F 157	F157 POC accepted 12/3/13 RTremblay RN/pmc	
-------	--	-------	--	--

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 11/13/2013
--	--	--	---

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 157 Continued From page 2

Per interview on 11/13/13 @ 10:07 AM with the NHA, s/he confirms that Resident #3's DPOA was not provided with any written notice in advance of the change in policy or in instituting the policy that originated in the year 2000 (Using Surveillance Equipment). Per interview on 11/13/13 @ 10:07 AM with the NHA, s/he confirms that there is no documentation to provide evidence that a meeting took place.

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:  
Based on clinical record review, observations,

F 157

F279 Corrective action

F 279

1. Resident #2 no longer resides in the facility
2. Residents with a desire to discharge from the facility have the potential to be affected by this alleged deficient practice.
3. Resident care plans will be audited to ensure a care plan is in place for discharge or long term placement.
4. Education will be provided to licensed nurses, the Admissions Coordinator, and the Social Service Director regarding the necessity of a discharge care plan to be in place for all residents. Those residents that live in the facility long term will have a care plan in place to reflect long term placement.

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 11/13/2013	
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 279	<p>Continued From page 3</p> <p>facility documentation and interviews for 1 of 6 sampled residents (Resident #2), the facility failed to develop a care plan to meet the resident's current needs regarding discharge planning &amp; coordination. The findings include:</p> <p>Resident #2 was admitted on 4/5/13 with diagnoses to include failure to thrive, weakness, hypertension, dementia, seizure disorder and depression, then was discharged to the Vermont Veterans Home on 7/13/13.</p> <p>Per record review, the Interdisciplinary Care Plan does not contain a plan for discharge. Per review of 7/2/13 Admission Coordinator notes identify that family stated "I guess Dad is being discharged tomorrow". Medical Record review of Social Service notes dated 6/19/13 state no plan for discharge, but family expresses wish for transfer at some point. This was confirmed by the Social Service Director during interview on 11/13/13 @ 9:49 AM.</p> <p>A Notice of Transfer and Discharge was issued to family and signed on 7/2/13 with no reason for discharge noted on the document. Per interview with the Admission Coordinator and Social Service Director on 11/13/13 @ 9:49 AM, confirmation is made that there is no documented reason for discharge on the transfer form. Per interview with Admission Coordinator and Social Service Director on 11/13/13 @ 9:49 AM, confirm that there was no care plan in place for discharge planning despite the fact that they were aware of the family's desire to transfer.</p>	F 279	<ol style="list-style-type: none"> <li>5. Education will be provided to staff responsible for filling out the Notice of Transfer or Discharge to include the specific reason for discharge.</li> <li>6. Random weekly audits will be done by the DON or designee of residents transferred or discharged from the facility to determine effectiveness of the plan.</li> <li>7. The results of the audits will be brought to the QA committee monthly x3 months by the DON or designee. Further frequency of the audits will be determined by the QA committee at that time.</li> <li>8. Corrective action will be complete by December 1, 2013</li> </ol> <p><i>F279 POC accepted 12/3/13 RTvenblay RN/AMC</i></p>	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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 11/13/2013
--	--	--	---

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 280	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Clinical Record Review, observations, review of facility documentation and interviews for 1 of 6 sampled residents (Resident #1), the facility failed to update Resident #1's care plan to meet current needs. The findings include:</p> <p>Resident #1 was admitted on 8/30/13 with a diagnoses that include status post motor vehicle accident (MVA) with fractures of the right and left tibia shafts, Lumbar 2 &amp; 11 vertebral fractures, multiple rib fractures, dislocation of the left ankle, post Polio Syndrome (Paraplegia), diabetes, Depression with Psychosis and Anehedonia (the inability to experience pleasure from activities usually found enjoyable).</p>	F 280	<p>F280 Corrective Action</p> <ol style="list-style-type: none"> <li>1. Resident #1's care plan has been updated to reflect current level of care and approaches to address his/her self-care deficits.</li> <li>2. Residents with self-care deficits have the potential to be affected by this alleged deficient practice.</li> <li>3. Care plans for residents will be audited to ensure their current level of care and approaches are accurate.</li> <li>4. Education will be provided to staff that have a responsibility to update care plans regarding the need to update care plans within 24 hours of a change in the plan of care.</li> <li>5. Random audits will be done weekly by the DON or designee x3 months to monitor effectiveness of the plan.</li> </ol>	
-------	--	-------	--	--

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

PRINTED: 11/21/2013  
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 11/13/2013
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)
F 280	Continued From page 5  Per medical record review, on 10/31/13 Resident #1 was seen at Fletcher Allen Health Care (FAHC), bilateral casts were removed and a walking boot applied to right foot and a boot and ankle stabilizer applied to left foot, which may be removed for bathing. Interdisciplinary Care Plan notes problem with self care deficit initiated on 8/30/13 with a target date of 12/19/13. Approaches to date included assistance is necessary due to bilateral lower extremity casts. As noted above, casts were removed on 10/31/13.  Per interview with Unit Manger (UM) on 11/12/13 @ 3:30 PM s/he confirms that the care plan has not been updated to include the use of a walking boot to right foot and a boot with an ankle stabilizer to left foot and the removal of bilateral casts.	F 280	6. The results of the audits will be brought to the QA committee monthly x3 months at which time further frequency of the audits will be further determined by the QA committee.  7. Corrective action will be complete by December 1, 2013  <i>F880 POC accepted 12/3/13 RTremblay RN/PMC</i>
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure services provided meet professional standards of quality for 1 of 6 residents in the sample regarding monitoring of a resident with a potential head injury (Resident #4). This citation is at the Immediate Jeopardy level. Findings include:  Per record review on 11/13/13 at 10:40 AM,	F 281	F 281 Corrective Action  1. Resident #4 no longer resides at the facility  2. Residents that experience a fall have the potential to be affected by this alleged deficient practice.  3. Upon notice of this finding extensive education began and was completed for Licensed Nurses and Licensed Nursing Assistants regarding the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>
---	---

(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 281	<p>Continued From page 6</p> <p>nursing staff failed to properly assess and monitor Resident #4 after sustaining a fall on 6/4/13. Resident #4 was admitted to the facility on 12/13/12. Diagnoses include Dementia, Gastroesophageal reflux disease, Gout, Hypertension, Depression, Atrial fibrillation, Osteopenia, Insomnia, Anxiety and Seizure activity. The Resident required extensive assistance with most activities of daily living. Fall risk assessments on 5/22/13 and 6/3/13 were scored at 19 and 22 respectively, indicating high fall risk.</p> <p>Resident #4 was found lying in a hallway flat on his/her stomach at approximately 7:30 PM on 6/4/13. Per a 6/4/13 7:44 PM incident note, the Resident had a hematoma with skin abrasion on the right side of his/her chin. Per interview with the Unit Manager (UM) on 11/13/13 at 12:40 PM, facility policy after a fall is to obtain neurological vital signs (NVS) every 15 minutes for 1 hour, every 30 minutes for 4 hours, every hour for 2 hours then every shift for 72 hours. NVS is an evaluation by a licensed professional that includes an assessment of the resident's level of consciousness, pupil response, motor functions, pain response and vital signs. Review of the facility Neurological Evaluation Flow Sheet indicates that NVS were done one time (exact time not recorded) on the 3:00 PM - 11:00 PM shift and not again after that. The UM confirmed that the NVS were not done per protocol on both the evening and night shifts after the Resident's fall.</p> <p>Per review of a written statement by a facility Registered Nurse (RN), a facility Licensed Nursing Assistant (LNA) reported that h/she was asked by "the nurse" to do vital signs on the</p>	F 281	<ul style="list-style-type: none"> <li>• Conducting Neurological Evaluations (including blood pressure, pulse, respirations, temperature, level of consciousness, pupil response, motor function of hand grasps and extremities, pain response, and other observations) are outside the scope of practice for Licensed Nursing Assistants and must be performed by a Licensed Nurse.</li> <li>• Licensed Nurses will conduct Neurological Evaluations for any fall that involves an actual head injury and all un-witnessed falls.</li> <li>• How and when to complete a neurological evaluation.</li> </ul>	
-------	--	-------	--	--

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

PRINTED: 11/21/2013  
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 11/13/2013
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 281	Continued From page 6	F 281	<ul style="list-style-type: none"> <li>When a patient sustains a fall, an evaluation for injury will be conducted and documented by a Licensed Nurse in the progress notes within the medical record status post a fall for a minimum of 72 hours every shift.</li> <li>A Fall Aftercare Protocol was developed and education also included the elements of the protocol</li> </ul> <p>4. Systemically the following changes were made and in-servicing done with staff:</p> <ul style="list-style-type: none"> <li>The Licensed Nurse on duty at the time of a resident fall will notify the DON promptly so that the DON can review the status with the Licensed Nurse and ensure compliance with the plan is maintained.</li> </ul>	

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET</b> <b>BARRE, VT 05641</b>		
(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 281	Continued From page 6	F 281	<ul style="list-style-type: none"> <li>Daily oversight will be provided by the Regional Director of Quality Improvement and/or the Vice President of Operations until the immediate jeopardy is confirmed by the state agency to have successfully been abated at which time continued oversight will be re-evaluated.</li> </ul> <ol style="list-style-type: none"> <li>Daily audits have been completed and are ongoing by the DON to identify other residents requiring neurological evaluations and monitor that compliance is being maintained with remedial measures initiated as needed.</li> <li>Results of the audits will be brought to the QA committee</li> </ol>		

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>
---	---

(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 281	<p>Continued From page 7</p> <p>Resident and stated that NVS were supposed to be done by the nurse. The LNA then told the nurse that the night nurse had in fact made her do the vitals on 6/4/13 and 6/5/13. The UM confirmed that doing NVS were outside an LNA's scope of practice and that NVS were to be done by a licensed nurse only.</p> <p>During a 11/13/13, 1:00 PM telephone call to the above mentioned LNA, the LNA stated that h/she had indeed been asked by the nurse to do NVS but when h/she tried the Resident refused. The LNA stated that h/she had been asked by nurses in other instances to do NVS and that h/she agreed to do them because h/she wanted to help.</p> <p>Per review of nursing notes from 6/5/13, the Resident was found unresponsive at 5:30 AM and was transferred via EMS to the hospital at approximately 6:00 AM. Per review of hospital records, the Resident was unresponsive while at the hospital and was placed on comfort care. Review of hospital diagnostic imaging reports show that the Resident was admitted with a right sided subdural hematoma (an accumulation of blood on the brain's surface beneath the skull) and a right maxillary sinus fracture. The Resident expired on 6/5/13 at approximately 8:00 PM.</p>	F 281	<p>by the DON monthly x6 months at which time further frequency of the audits will be determined by the QA committee.</p> <p>7. Corrective action was complete on November 19, 2013.</p> <p><i>F281 POC accepted 12/3/13 RTremblay RN/PMC</i></p>	
F 309 SS=J	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 accordance with the comprehensive assessment and plan of care.</p>	F 309	<p>F 309 Corrective Action</p> <ol style="list-style-type: none"> <li>1. Resident #4 no longer resides at the facility</li> <li>2. Residents that experience a fall have the potential to be affected by this alleged deficient practice.</li> </ol>	

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 11/13/2013
--	--	--	---

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 309	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure each resident receives the necessary care and services to maintain the highest practicable physical well-being for 1 of 6 sampled residents (Resident # 4) regarding proper monitoring after a potential head injury. This is cited at the Immediate Jeopardy level. Findings include:</p> <p>Per record review on 11/13/13 at 10:40 AM, nursing staff failed to properly assess and monitor Resident #4 after sustaining a fall on 6/4/13. Resident #4 was admitted to the facility on 12/13/12. Diagnoses include Dementia, Gastroesophageal reflux disease, Gout, Hypertension, Depression, Atrial fibrillation, Osteopenia, Insomnia, Anxiety and Seizure activity. The Resident required extensive assistance with most activities of daily living. Fall risk assessments on 5/22/13 and 6/3/13 were scored at 19 and 22 respectively, indicating high fall risk.</p> <p>Resident # 4 was found lying in a hallway flat on his/her stomach at approximately 7:30 PM. Per a 6/4/13 7:44 PM incident note, the Resident had a hematoma with skin abrasion on the right side of his/her chin. Per interview with the Unit Manager (UM) on 11/13/13 at 12:40 PM, facility policy after a fall is to obtain neurological vital signs (NVS) every 15 minutes for 1 hour, every 30 minutes for 4 hours, every hour for 2 hours then every shift for 72 hours. NVS is an evaluation by a licensed professional that include level of consciousness,</p>	F 309	<p>3. Upon notice of this finding extensive education began and was completed for Licensed Nurses Licensed Nursing Assistants regarding the following:</p> <ul style="list-style-type: none"> <li>• Conducting Neurological Evaluations (including blood pressure, pulse, respirations, temperature, level of consciousness, pupil response, motor function of hand grasps and extremities, pain response, and other observations) are outside the scope of practice for Licensed Nursing Assistants and must be performed by a Licensed Nurse.</li> <li>• Licensed Nurses will conduct Neurological Evaluations for any fall that involves an actual head injury and all un-witnessed falls.</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>
---	---

(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 309	<p>Continued From page 9</p> <p>pupil response, motor functions, pain response and vital signs. Review of the facility Neurological Evaluation Flow Sheet indicates that NVS were done one time (exact time not recorded) on the 3:00 PM - 11:00 PM shift and not again after that. The UM confirmed that the NVS were not done per protocol on both the evening and night shifts after the Resident's fall.</p> <p>Per review of a written statement by a facility Registered Nurse (RN), a facility Licensed Nursing Assistant (LNA) reported that h/she was asked by "the nurse" to do vital signs on the Resident and stated that NVS were supposed to be done by the nurse. The LNA then told the nurse that the night nurse had in fact made her do the vitals on 6/4/13 and 6/5/13. The UM confirmed that doing NVS were outside an LNA's scope of practice and that NVS were to be done by a licensed nurse only.</p> <p>During a 11/13/13, 1:00 PM telephone call to the above mentioned LNA, the LNA stated that h/she had indeed been asked by the nurse to do NVS but when h/she tried the Resident refused. The LNA stated that h/she had been asked by nurses in other instances to do NVS and that h/she agreed to do them because h/she wanted to help. Per review of nursing notes from 6/5/13, the Resident was found unresponsive at 5:30 AM and was transferred via EMS to the hospital at approximately 6:00 AM. Per review of hospital records, the Resident was unresponsive while at the hospital and was placed on comfort care. Review of hospital diagnostic imaging reports show that the Resident was admitted with a right sided subdural hematoma (an accumulation of blood on the brain's surface beneath the skull) and a right maxillary sinus fracture. The Resident</p>	F 309	<ul style="list-style-type: none"> <li>• How and when to conduct a neurological evaluation</li> <li>• When a patient sustains a fall, an evaluation for injury will be conducted and documented by a Licensed Nurse in the progress notes within the medical record status post a fall for a minimum of 72 hours every shift.</li> <li>• A Fall Aftercare Protocol was developed and education also included the elements of the protocol</li> </ul>	
-------	---	-------	--	--

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

PRINTED: 11/21/2013  
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 11/13/2013
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 309	Continued From page 8	F 309	<p>4. Systemically the following changes were made and in-servicing done with staff:</p> <ul style="list-style-type: none"> <li>The Licensed Nurse on duty at the time of a resident fall will notify the DON promptly so that the DON can review the status with the Licensed Nurse and ensure compliance with the plan is maintained.</li> <li>Daily oversight will be provided by the Regional Director of Quality Improvement and/or the Vice President of Operations until the immediate jeopardy is confirmed by the state agency to have successfully been abated at which time continued oversight will be re-evaluated.</li> </ul>		

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

PRINTED: 11/21/2013  
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 11/13/2013
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 309	Continued From page 8	F 309	<ol style="list-style-type: none"> <li>5. Daily audits have been completed and are ongoing by the DON to identify other residents requiring neurological evaluations and monitor that compliance is being maintained with remedial measures initiated as needed.</li> <li>6. Results of the audits will be brought to the QA committee by the DON monthly x6 months at which time further frequency of the audits will be determined by the QA committee.</li> <li>7. Corrective action was complete on November 19, 2013</li> </ol>		

F309 POC accepted 12/3/13 RTVembury RN/AMC

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 11/13/2013
--	--	--	---

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 309  F 354 SS=F	<p>Continued From page 10 expired on 6/5/13 at approximately 8:00 PM.</p> <p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staffing records, facility documents and staff interviews, the facility failed to meet the requirements of the presence of a Registered Nurse (RN) in the facility for at least 8 consecutive hours a day, 7 days a week unless a waiver has been obtained. The findings include: Per review of staffing schedules for the months of September, October and November 2013 (to date 11/13/13), there is no evidence that on four (4) Saturdays and two (2) Sundays, an RN's was not in the building 8 consecutive hours a day over a 24 hour period. On one (1) Saturday, documentation shows an RN was in the building for just 1.75 hours in a 24 hour period. Per interview with the Nursing Home</p>	F 309  F 354	<p>F 354 Corrective Action</p> <ol style="list-style-type: none"> <li>1. No residents were negatively affected by this alleged deficient practice.</li> <li>2. Residents who reside in the center have the potential to be affected by this alleged deficient practice</li> <li>3. In-servicing has been done for staff to include: If an RN that is scheduled to work is unable to fulfill his/her obligation, the DON will be notified immediately so that alternative RN coverage can be arranged.</li> <li>4. Staff responsible for scheduling licensed nurses has been provided with education on the requirement of 8 consecutive hours of RN coverage 7 days a week.</li> <li>5. The schedule will be reviewed daily to ensure the 8 consecutive hours of RN coverage is met. The schedule will be reviewed by the DON.</li> </ol>	

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

PRINTED: 11/21/2013  
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 11/13/2013
--	--	--	---

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
--------------------	--	---------------	---	----------------------

<p>F 354</p> <p>F 490 SS=J</p>	<p>Continued From page 11</p> <p>Administrator on 11/13/13 @ 1 PM, s/he confirmed that there were no RN's in the building on 9/14/13, 10/12/13, 10/26/13, 10/27/13, 11/9/13, 11/10/13 and 1.75 hours of an RN in a 24 hour period on 9/28/13. Confirmation was also made that a waiver has not been requested.</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being for 1 of 6 sampled residents (Resident # 4). Findings include:</p> <p>Per review of facility investigative documentation regarding a fall Resident #4 sustained on 6/4/13, the facility administration failed to conduct a thorough investigation and failed to take action to ensure residents were being properly assessed and monitored by staff.</p> <p>Per record review on 11/13/13 at 10:40 AM, nursing staff failed to properly assess and monitor Resident # 4 after sustaining a fall on 6/4/13. Resident # 4 was found lying in a hallway flat on his/her stomach at approximately 7:30 PM. Per a 6/4/13 7:44 PM incident note, the Resident had a</p>	<p>F 354</p> <p>F 490</p>	<p>6. The DON will review the PPD daily to confirm the requirement has been met and documented.</p> <p>7. These daily audits will be brought to the QA committee monthly x3 months by the DON to monitor effectiveness of the plan. After 3 months the QA committee will determine further frequency of the audits.</p> <p>8. Corrective action will be complete by December 1, 2013</p> <p><i>F354 POC accepted 12/3/13 RTrembdayRN/PMC</i></p> <p>F 490 Corrective Action</p> <p>1. Resident #4 no longer resides at the facility</p> <p>2. Residents that experience a fall have the potential to be affected by this alleged deficient practice.</p>	
------------------------------------	--	---------------------------	--	--

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>
---	---

(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 490	<p>Continued From page 12</p> <p>hematoma with skin abrasion on the right side of his/her chin. Per interview with the Unit Manager (UM) on 11/13/13 at 12:40 PM, facility policy after a fall is to obtain neurological vital signs (NVS) every 15 minutes for 1 hour, every 30 minutes for 4 hours, every hour for 2 hours then every shift for 72 hours. Review of the facility Neurological Evaluation Flow Sheet indicates that NVS were done one time (exact time not recorded) on the 3:00 PM - 11:00 PM shift and not again after that. The UM confirmed that the NVS were not done per protocol on both the evening and night shifts after the Resident's fall.</p> <p>Per review of a written statement by a facility Registered Nurse (RN), a facility Licensed Nursing Assistant (LNA) reported that h/she was asked by "the nurse" to do vital signs on the Resident and stated that NVS were supposed to be done by the nurse. The LNA then told the nurse that the night nurse had in fact made her do the vitals. The UM confirmed that doing NVS were outside an LNA's scope of practice and that NVS were to be done by a licensed nurse only.</p> <p>During a 11/13/13, 1:00 PM telephone call to the above mentioned LNA, the LNA stated that h/she had indeed been asked by the nurse to do NVS but when h/she tried the Resident refused. The LNA stated that h/she had been asked by nurses in other instances to do NVS and that h/she agreed to do them because h/she wanted to help. Per review of nursing notes from 6/5/13, the Resident was found unresponsive at 5:30 AM and was transferred via EMS to the hospital at approximately 6:00 AM. Per review of hospital records, the Resident was unresponsive while at the hospital and was placed on comfort care. Review of hospital diagnostic imaging reports</p>	F 490	<p>3. Upon notice of this finding extensive education began and was completed for Licensed Nurses Licensed Nursing Assistants regarding the following:</p> <ul style="list-style-type: none"> <li>• Conducting Neurological Evaluations (including blood pressure, pulse, respirations, temperature, level of consciousness, pupil response, motor function of hand grasps and extremities, pain response, and other observations) are outside the scope of practice for Licensed Nursing Assistants and must be performed by a Licensed Nurse.</li> <li>• Licensed Nurses will conduct Neurological Evaluations for any fall that involves an actual head injury and all un-witnessed falls.</li> </ul>	
-------	--	-------	--	--

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>
---	---

(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 490	Continued From page 13	F 490	<ul style="list-style-type: none"> <li>• How and when to conduct a neurological evaluation</li> <li>• When a patient sustains a fall, an evaluation for injury will be conducted and documented by a Licensed Nurse in the progress notes within the medical record status post a fall for a minimum of 72 hours every shift.</li> <li>• A Fall Aftercare Protocol was developed and education also included the elements of the protocol</li> </ul>	
-------	------------------------	-------	--	--

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET</b> <b>BARRE, VT 05641</b>		
(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 490	Continued From page 13	F 490	4. Systemically the following changes were made and in-servicing done with staff: <ul style="list-style-type: none"> <li>The Licensed Nurse on duty at the time of a resident fall will notify the DON promptly so that the DON can review the status with the Licensed Nurse and ensure compliance with the plan is maintained.</li> <li>Daily oversight will be provided by the Regional Director of Quality Improvement and/or the Vice President of Operations until the immediate jeopardy is confirmed by the state agency to have successfully been abated at which time continued oversight will be re-evaluated.</li> <li>A thorough investigation will be</li> </ul>	

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>		
(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 490	Continued From page 13	F 490	<p>conducted by the DON for every fall to include: details of the incident, witness statements and interview if applicable, resident interview as able, record review, medication review, environmental review.</p> <ul style="list-style-type: none"> <li>An investigation summary will follow the investigation addressing at a minimum the following: details of the incident, witness names, a determination of the cause of the fall if able to determine, any injuries noted, any issues identified throughout the course of the investigation and remedies imposed to address those issues including remedial measures as indicated.</li> </ul>		

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>		
(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 490	Continued From page 13	F 490	In addition, new interventions will be addressed to help prevent further falls for the specific resident.  <ul style="list-style-type: none"> <li>The Executive Director will be notified of all falls that occur.</li> <li>The Executive Director will review the investigation summary for all falls and indicate approval by signing the investigation summary.</li> </ul>		

- Daily audits have been completed and are ongoing by the DON to identify other residents requiring neurological evaluations and monitor that compliance is being maintained with remedial measures initiated as needed.

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

PRINTED: 11/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ROWAN COURT HEALTH &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>378 PROSPECT STREET BARRE, VT 05641</b>
---	---

(X4) IO 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 490	<p>Continued From page 13</p> <p>show that the Resident was admitted with a right sided subdural hematoma and a right maxillary sinus fracture. The Resident expired on 6/5/13 at approximately 8:00 PM</p> <p>On 11/13/13 at 1:55 PM, the facility Executive Director (ED), who is also the Licensed Nursing Home Administrator, confirmed that h/she was not aware that Resident # 4 had not been properly assessed despite a written statement from a facility Registered Nurse indicating this. The ED also confirmed that the facility had not taken steps to ensure that resident were being properly assessed. The ED also confirmed that a complete investigation had not been conducted.</p>	F 490	<p>6. Results of the audits will be brought to the QA committee by the DON monthly x6 months at which time further frequency of the audits will be determined by the QA committee.</p> <p>7. Corrective action to be complete by December 1, 2013</p> <p><i>F490 POC accepted 12/13/13 R/Tremblay R/A/ML</i></p>	
-------	---	-------	--	--