



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

November 22, 2010

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

Provider ID #:475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 26, 2010**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

RECEIVED PRINTED: 11/05/2010
Division of FORM APPROVED
NOV 12 10 OMB NO. 0938-0391
Licensing and Protection

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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 C 10/26/2010 |
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| NAME OF PROVIDER OR SUPPLIER ROWAN COURT HEALTH & REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 281 SS=D | <p>An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</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 family and staff interview and record review, the facility failed to assure that services being provided meet professional standards of practice regarding medication administration and infection control for 1 resident in the applicable sample. (Resident #2) Findings include:</p> <p>1. Per interview and record review, the facility failed to ensure that nursing staff used standard safety precautions and correct procedures around the administration of injectable medication. Per family interview and record review on 10/26/10, Resident #2 sustained a needle stick on 10/24/10 at approximately 8 PM with an insulin syringe that was previously used that same evening on another resident. Confirmed in interview on 10/26/10 at 2:08 PM with the Assistant Director of Nursing (ADON) and the Unit Manager (UM), the Medication Nurse used an insulin syringe to administer insulin to one resident and failed to correctly use the sliding safety device to cover and lock the cap on the syringe needle. The nurse then placed the empty syringe in his/her pocket, where there was more than one syringe, instead of disposing of it in the safety needle box provided in the resident's room. The Medication</p> | F 281 | <p>F 281 Residents #2 was not harmed by this alleged deficient practice.</p> <p>Residents blood sample was negative for any infection.</p> <p>Any resident receiving injectable medications has the potential to be affected by this alleged deficit practice.</p> <p>The medication nurse received re-education regarding safe administration of medication.</p> <p>The nurses were re-educated on safe administration of medication.</p> <p>Random audits of injectable medication passes will be conducted weekly x 90 days.</p> <p>The results of all audits will be reported to the facility QA committee for review x 90 days.</p> <p>The DNS/designee will be responsible for compliance.</p> <p>Corrective Action date November 26, 2010.</p> <p><i>F281 POC Accepted 11/19/10 Administrator</i></p> | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 11/16/2010 |
|--|-------------------------------|--------------------------------|

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 281 | Continued From page 1 Nurse then transported the syringe to Resident #2, "grabbed the wrong syringe out of the pocket" and stuck Resident #2 with the used insulin syringe. Also confirmed per interview with the ADON and UM on 10/26/10 at 2:08 PM, the Medication Nurse reported the incident immediately to the Evening Supervisor, the family and medical provider were notified, and the facility Accidental Needlestick Injury policy was implemented, including having both residents tested for the blood-borne pathogens identified in the policy. The Medication Nurse received corrective re-education regarding safe administration of medication and a facility wide nursing Staff Development program on this topic was conducted after the incident. Also confirmed, the facility uses only syringes with safety devices and there are safety needle boxes in all resident rooms. Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, pg. 17. | F 281 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and | F 441 | Random audits of injectable medication passes will be conducted weekly x 90 days. The results of all audits will be reported to the facility QA committee for review x 90 days. The DNS/designee will be responsible for compliance. Corrective Action date November 26, 2010. | |

F441 POC Accepted 11/19/10 PmatARN

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| F 441 | <p>Continued From page 2</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on family and staff interview and record review, the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary environment to help prevent the transmission of disease and infection for 1 resident in the applicable sample. (Resident #2) Findings include:</p> <p>Per interview and record review, the facility failed to ensure that nursing staff used standard safety precautions and correct procedures around the use of injectable medication. Per family interview and record review on 10/26/10, Resident #2</p> | F 441 | | | |

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| F 441 | Continued From page 3 sustained a needle stick on 10/24/10 at approximately 8 PM with an insulin syringe that was previously used on another resident that same evening. Confirmed in interview on 10/26/10 at 2:08 PM with the Assistant Director of Nursing and the Unit Manager, the Medication Nurse used an insulin syringe to administer insulin to one resident and failed to correctly use the sliding safety device to cover and lock the cap on the syringe needle. The nurse then placed the empty syringe in his/her pocket where there was more than one syringe, instead of disposing of it in the safety needle box provided in the resident's room. The Medication Nurse then transported the syringe to Resident #2, "grabbed the wrong syringe out of the pocket" and stuck the resident with the used insulin syringe. Also confirmed per interview with the ADON and UM on 10/26/10 at 2:08 PM, the Medication Nurse reported the incident immediately to the Evening Supervisor, the family and medical provider were notified, and the facility Accidental Needlestick Injury policy was implemented, including having both residents tested for the blood-borne pathogens identified in the policy. The Medication Nurse received corrective re-education regarding safe administration of medication and a facility wide nursing Staff Development program on this topic was conducted after the incident. Also confirmed, the facility uses only syringes with safety devices and there are safety needle boxes in all resident rooms. | F 441 | | |