

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

December 30, 2011

Mr. James Beeler, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641-5421

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **November 16, 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:ne

Enclosure



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

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PRINTED: 11/30/2011
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 _____	Licensing and Protection (X3) DATE SURVEY COMPLETED C 11/16/2011
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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	INITIAL COMMENTS	F 000	/	
F 280 SS=D	<p>An on-site complaint investigation was conducted on 11/8/11 and 11/10/11 by the Division of Licensing & Protection. The investigation was completed on 11/16/11. The following regulatory deficiencies were identified.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</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 record review and confirmed through staff interview the facility failed to assure that the comprehensive care plan was revised to reflect current status for one resident. (Resident #1). Findings include:</p>	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator (X6) DATE: 12/9/2011

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. *[Signature]*

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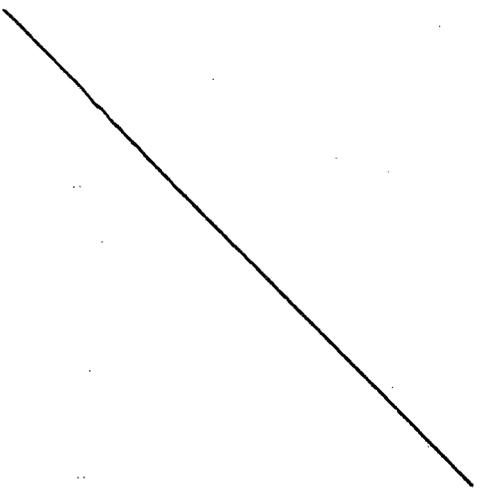
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F 280	<p>Continued From page 1</p> <p>Per record review, Resident #1's comprehensive care plan had not been revised to reflect a significant weight loss or interventions implemented to address that weight loss, nor had it been updated to reflect an identified pressure ulcer.</p> <p>The facility Weight Report for October 2011 identified that Resident #1 had a "Rapid wgt loss noted in September, etiology unclear". A Weight Change Note, written by the RD (Registered Dietician), on 10/4/11, identified that the resident's weight was down 10.4% in a month and down 11.2% in 2 months. The note stated that the resident's; "PO (by mouth) intake varies, overall good....", and noted that the resident was on Ensure (nutritional supplement) 4 oz twice daily to encourage adequate intake. The note further stated that the issue had been discussed at weight meeting and recommendations included; Mighty Shakes (nutritional supplement) every day to "boost intake, support wgt maintenance". Although the care plan, initiated on 7/18/11 reflected the Potential for alteration in Nutrition; less than body requirements, it had not been updated to reflect the addition of Ensure BID (twice daily) in August 2011, the significant weight loss sustained by the resident in September, nor the new recommendations, identified on 10/4/11, of adding Mighty Shakes as an intervention. A subsequent Nutrition Quarterly Assessment note, dated 10/18/11, recommended increasing the Mighty Shakes to BID at that time, and the care plan had not been revised to reflect this.</p> <p>In addition, although the resident's initial care</p>	F 280	<p>F 280</p> <p>Resident # 1 no longer resides in the facility.</p> <p>Resident #1 was not harmed by this Alleged deficient practice.</p> <p>All residents experiencing weight loss or pressure ulcers are at risk to be effected by this alleged deficient practice.</p> <p>A review of all resident care plans with significant weight loss or pressure ulcers will be completed for care plan documentation.</p> <p>Compliance will be monitored through weekly interdisciplinary team meetings and concurrent review.</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: December 16, 2011.</p>	
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12/22/11 Bc [signature]
B Home / SCR

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F 280	Continued From page 2 plan, dated 7/18/11, identified the resident at risk for Potential Alteration in Skin Integrity, it had not been updated to reflect the actual alteration in skin integrity identified on the facility Bath Record, dated October 28, 2011, which revealed the presence of an "open area buttocks outside acquired". During interview, on the afternoon of 11/10/11, the RN Unit Manager confirmed that Resident #1's care plan had not been updated to reflect the changes in the resident's skin and nutritional status.	F 280	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 review and confirmed through staff interview the facility failed to assure consistent implementation of the care plan for 1 resident. (Resident #1). Findings include: Per record review staff failed to consistently weigh Resident #1 in accordance with the established plan of care. The resident, who had been identified as at risk for Potential for Alteration in Nutrition; less than body requirements, had a care plan, dated 7/18/11, that directed staff to "weigh per policy, weekly and as needed" and to "assess for possible use of medication for appetite stimulants...evaluate	F 282	

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F 282	Continued From page 3 current medication regime to assure no appetite suppression". The resident's weight was recorded as 177 lbs on 8/3/11 and 173.9 lbs on 8/10/11, revealing a weight loss of 3.1 lbs in that 7 day period. However, there was no evidence of a re-weight until 3 weeks later, on 8/31/11, at which time the weight was 170.7 lbs., a loss of another 3.2 lbs. Subsequent attempts to obtain the resident's weight occurred on only two more occasions, each a week apart, on 9/7/11 and 9/15/11, respectively. Although on each of those attempts the resident refused to be weighed, and despite evidence of previous, ongoing weight loss, and the care plan direction to weigh "weekly and as needed", no other attempts were made until 9/21/11 at which time the resident's weight was 155.8 lbs. reflecting a weight loss of 14.9 lbs during the 3 week period between 8/31/11 and 9/21/11. Although 2 separate Nutrition assessment notes, on 10/4/11 and 10/18/11, reflected some assessment of the weight loss there was no evidence of evaluation of current medications the resident was taking nor any indication that assessment for possible use of appetite stimulants was conducted. The RN Unit Manager confirmed, during interview on the afternoon of 11/10/11, staff's failure to follow the care plan as mentioned above.	F 282	If any resident refuses a weight, staff will re-attempt the next day and x 2 days. Compliance will be monitored through weekly interdisciplinary team meetings and concurrent review. 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: December 16, 2011. <i>12/22/11 POC annette</i> <i>B Done / 50</i>	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		

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F 314	<p>Continued From page 4</p> <p>individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on chart review and confirmed through staff interview the facility failed to provide treatment and services to promote healing of an identified pressure ulcer for 1 resident. (Resident #1). Findings include:</p> <p>Per record review, on 11/8/11 and 11/10/11, staff failed to assess and treat an identified open area of skin, failed to notify the physician and failed to follow the facility's policy regarding skin management, for Resident #1, who was identified on admission, on 7/17/11, as at risk for potential Alteration in Skin Integrity. The resident was discharged on 10/20/11 and re-admitted to the facility on 10/24/11, following an acute care stay at the hospital.</p> <p>The policy, titled Skin Care Management System, states; under Practice Guidelines: 12. b. 2. ..."The nurse should assure that treatment interventions, care plan and the appropriate Skin documentation record are initiated in a timely manner. Under Documentation Guidelines: 1. "When a wound is identified, measure and assess the wound and notify: a. resident's physician (obtain treatment orders and request MD visit, as indicated); b. family member/responsible party; and c. Registered Dietician and therapy staff."</p>	F 314	<p>F 314</p> <p>Resident #1 no longer resides in the facility.</p> <p>Resident #1 pressure ulcer was treated and resolved.</p> <p>All residents have the potential to be effected by this deficit practice.</p> <p>All Nurses will be inserviced on the procedure for reporting and interventions for newly identified pressure areas.</p> <p>Random audits will be done weekly x 90 days.</p> <p>The results of all audits will he 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: December 16, 2011</p> <p><i>12/22/11 Doc unnt</i> <i>12/22/11 B. Home / B</i></p>	

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F 314	Continued From page 5 Per review of the MDS (Minimum Data Set) skin condition section, completed on re-admission and dated 10/24/11, there was a reddened area on the resident's buttocks measuring 3 cm x 5 cm that was blanchable, with intact skin. The Bath Record, identified by the DNS (Director of Nursing Services) and RN Unit Manager as the form utilized by staff to document weekly skin assessments, dated October 28, 2011 revealed the resident had an "open area buttocks outside acquired". There was no evidence of any further skin assessment or treatment. In addition, there was no evidence the physician or family member/responsible party had been notified. The resident was re-admitted to the hospital 3 days later, on 10/31/11, with an acute condition of the knee and a History and Physical completed by the attending physician at that time stated, under PLAN:..."10. Wound care. Patient did come in with a buttock decubitus ulcer and therefore will have wound care see the patient." A Wound Care note completed by the hospital Wound Care Nurse at 10:39 AM on 10/31/11 stated that the "sacral area has a 5 cm L x 4 cm W x 1 cm...wound". Resident #1 was again re-admitted to the facility 3 days later, on 11/3/11, and a skin assessment, at that time, identified pressure ulcers as 4 small Stage 2 areas on the coccyx. Treatment by the facility was initiated at the time of that re-admission. During interview on the afternoon of 11/10/11, the RN Unit Manager confirmed that the facility policy had not been followed and stated s/he had not been aware of any pressure ulcers or open areas of skin on Resident #1 prior to the skin assessment on 11/3/11 on return from the hospital. The facility wound nurse, who was also	F 314			

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F 314	Continued From page 6 present during the interview, stated that s/he also had no knowledge of any wound prior to 11/3/11. Both nurses stated that weekly skin assessments are completed by nurses. If any change in skin condition the wound nurse is to be notified, an assessment of the wound is completed by the wound nurse, the physician is to be notified by nursing staff and treatment initiated. Both confirmed that did not occur for Resident #1.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 resident at risk for weight loss maintained acceptable parameters of nutrition. (Resident #1). Findings include: Per record review, staff failed to follow facility policies and procedures regarding unplanned weight loss, failed to consistently implement the care plan and failed to address, in a timely manner, a significant weight loss by Resident #1. The resident, who was admitted to the facility on	F 325	 F 325 Resident #1 no longer resides in the facility. All residents have the potential to be effected by this alleged deficient practice. A review of all residents weights has been completed. If any resident refuses a weight, staff will re-attempt the next day and x 2 days. The MD will be notified within 24 hours of refusals. If there is a significant weight loss identified, the MD will be notified within 24 hours.	

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F 325	<p>Continued From page 7</p> <p>7/17/11, had an initial Nutrition Assessment, dated 7/24/11, that stated s/he had been admitted to increase strength and functioning, and identified him/her at high nutritional risk. A physician progress note, dated 8/16/11, stated; "since being here [s/he] has actually been quite stable." The note identified that the resident had a history of Failure to Thrive and the Plan included: "...will start Ensure and discuss with dietician."</p> <p>Per review the facility's policy titled; Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol (Revised April 2007), directed staff to "report to the physician significant weight gains or losses..." and "The physician will review possible causes of anorexia or weight loss with the nursing staff and/or dietitian before ordering interventions." The facility's Weight Monitoring Standard; Practice Guidelines, stated: 2. Criteria for Re-Weighs: " a. Review of the worksheet will include focusing on unplanned weights that appear to be incorrect (i.e., variance of more than five (5) pounds in 30 days or three (3) pounds in seven (7) days", "...Re-weighs must be completed within 24 hours, in the presence of a licensed nurse."</p> <p>The resident's weight was recorded as 177 lbs on 8/3/11 and 173.9 lbs on 8/10/11, revealing a weight loss of 3.1 lbs in that 7 day period. However, there was no evidence of a re-weight until 3 weeks later, on 8/31/11, at which time the weight was 170.7 lbs., a loss of another 3.2 lbs. Subsequent attempts to obtain the resident's weight occurred on only two more occasions, each a week apart, on 9/7/11 and 9/15/11, respectively. Although on each of those attempts the resident refused to be weighed, and despite</p>	F 325	<p>All Mighty Shakes ordered will be recorded on the medication administration record.</p> <p>Nurses will be inserviced on afore mentioned.</p> <p>Random audits will be done weekly x 90 days. 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: December 16, 2011</p> <p><i>12.22-11 POC complete</i> <i>B Done 1/5</i></p>	
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F 325	Continued From page 8 evidence of previous, ongoing weight loss, no other attempts were made until 9/21/11 at which time the resident's weight was 155.8 lbs. Although there is evidence that the resident had refused several meals during this period, s/he experienced a significant weight loss of 14.9 lbs during the 3 week period between 8/31/11 and 9/21/11, that was not addressed by staff until 10/4/11. In addition there is no evidence that the physician was notified until an Interdisciplinary Note, dated 10/25/11 stated: Call to Dr...today "discussed [resident's] hx [history]of weight loss" and poor appetite..."see new orders for Remeron." The facility Weight Report for October 2011 identified that Resident #1 had a "Rapid wgt loss noted in September, etiology unclear". A Weight Change Note, written by the RD (Registered Dietician), on 10/4/11, identified that the resident's weight was down 10.4% in a month and down 11.2% in 2 months. The note stated that the resident's; "PO [by mouth] intake varies, overall good...", and noted that the resident was on Ensure [nutritional supplement] 4 oz twice daily to encourage adequate intake. The note further stated that the issue had been discussed at weight meeting and recommendations included; Mighty Shakes (nutritional supplement) every day to "boost intake, support wgt maintenance". Despite the assessment and recommendation by the RD, there was no evidence that the resident ever received the Mighty Shakes and, although the resident refused a subsequent weight on 9/28/11 there was no further attempt to re-weigh the resident until 10/9/11 at which time s/he weighed 150.5 lbs. In addition, although the resident did continue to receive Ensure BID (twice daily), and	F 325			

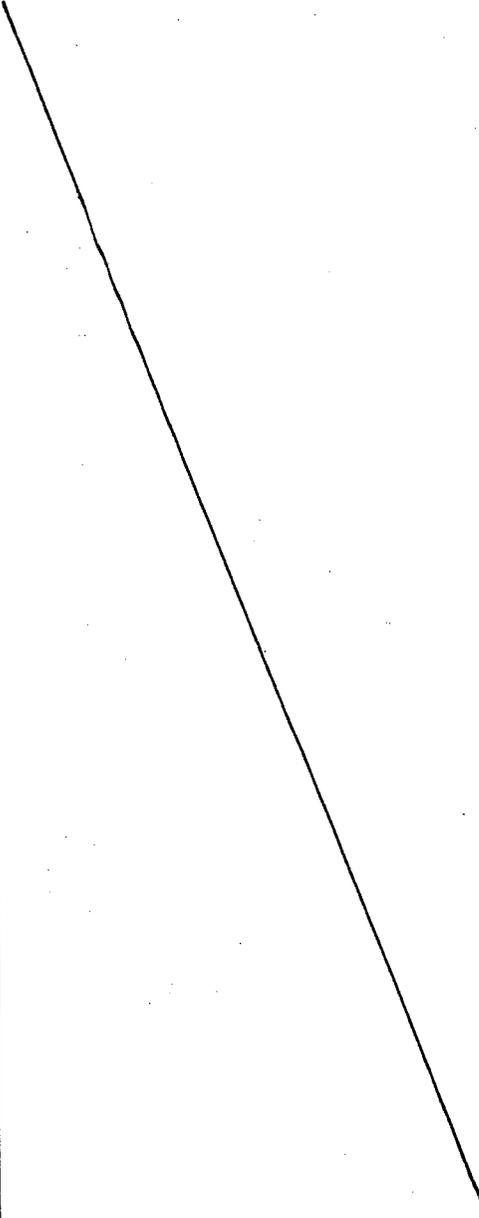
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F 325	<p>Continued From page 9</p> <p>the subsequent note by the RD, Nutrition Quarterly Assessment note, dated 10/18/11, indicated that the resident was receiving Mighty Shakes and recommended increasing the Mighty Shakes to BID at that time, there was no evidence that the resident had ever received the Mighty Shakes.</p> <p>During interview, on the afternoon of 11/8/11 the DNS (Director of Nursing Services) confirmed that weights had not been obtained consistently on a weekly basis in accordance with the care plan and confirmed there was no evidence to indicate that the resident had received the Mighty Shake supplements in accordance with the RD's recommendation.</p> <p>The RD stated, during a telephone interview at 5:10 PM on 11/8/11, that weights are obtained on residents on a weekly basis on their bath/shower day, and that s/he reviews weights on all residents on a weekly basis to identify, evaluate and address any issues. S/he was not aware of any process regarding re-weighing residents, with weight loss, and was unable to state why Resident #1's significant weight loss was not addressed until 2 weeks following the loss recorded on 9/21/11.</p> <p>Per interview, at 5:20 PM on 11/8/11, the NP (Nurse Practitioner) involved in Resident #1's care, confirmed that there was no evidence that the physician had been notified of the significant weight loss until 10/25/11. The NP stated that Ensure had been ordered in August related to labs drawn that identified a low albumin level. S/he stated that, if a resident had known weight loss and refused to be weighed on their shower</p>	F 325		
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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 11/16/2011
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 325	Continued From page 10 day, s/he would expect staff to attempt to re-weigh the resident as soon as possible, and not wait until the following week to obtain a weight. During interview on the afternoon of 11/10/11 the RN Unit Manager confirmed that the facility's Policy & Protocol for unplanned weight loss had not been followed, that Resident #1's weight loss issue had not been addressed until 10/4/11, that there was no evidence that the physician had been notified until 10/25/11 or that the resident had ever received Mighty Shakes in accordance with the RD recommendations.	F 325		