

Division of Licensing and Protection  
103 South Main Street  
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

May 21, 2015

Ms. Heather Filonow,  
Rowan Court Health & Rehab  
378 Prospect Street  
Barre, VT 05641-5421

Dear Ms. Filonow:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 29, 2015**. 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

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/29/2015
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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
F 000	INITIAL COMMENTS	F 000	Preparation and/or execution of this plan of correction does not constitute the providers admission of/or agreement with the alleged violations or conclusion set fourth in this statement of deficiencies. This plan of correction is prepared and/or executed as required by State and Federal Law.	
F 253 SS-E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to ensure that resident rooms, care areas and equipment are adequately maintained in a sanitary, safe and comfortable manner. The findings include the following:  Per the environmental tour with the Maintenance Supervisor and the Administrator on 04/28/15 at 12:00 PM, the following was noted:  The following resident room's ceiling tiles were heavily discolored with brown marks, stained, missing and/or broken; Rooms #155, 159, 169, 170, 171, 172, 173 and 175.  The resident's baseboard ducts in rooms #124, 125 and 126 presented with large accumulation of fuzz and dust.  Rooms #113 and #177 bathrooms had a build up of scale on the fixtures and/or vents.	F 253	<b>F253. 483.15(h)(2)</b>  No residents were negatively affected by this alleged deficient practice.  Residents residing in the facility have the potential to be affected by this alleged deficient practice.  Ceiling tiles in identified rooms have been replaced. Baseboard ducts in identified rooms have been cleaned. Scale build up on bathroom fixtures and/or vents in identified rooms has been removed. The ventilation ducts and heaters in the shower rooms have been cleaned. The double door on Wing 1 has been repaired. Resident #56 wheelchair cushion has been replaced.  Education has been provided to staff to ensure that resident rooms, care areas, and equipment are adequately maintained in a sanitary, safe, and comfortable manner.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Heather Gilman* TITLE *Executive Director* (X6) DATE *5/19/2015*

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 The shower rooms' ventilation ducts and heaters, on each Wing, were found to be heavily caked with dust and debris.  The double door, near Wing 1 in the main dining room, was observed to have a sharp protruding piece of metal at approximately ankle height.  In addition, Resident #56's wheelchair cushion was heavily stained with dried food debris.  The Maintenance Supervisor and Administrator confirmed the above findings at that time.	F 253	Random audits are being conducted 3 times weekly by the Executive Director or designee to monitor the effectiveness of the plan. The results of the audits are being reported to the QAA committee for three months at which time the QAA committee will determine the continued duration of the audits.  Corrective action will be completed by 5/29/15.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that it is free of medication error rates of five percent or greater. For 2 out of 37 medication administration observations, errors occurred, which resulted in the error rate exceeding 5%. The findings include the following:  Per observation on 4/28/15 at approximately 1616 (4:16 PM) the Registered Nurse (RN) administered Novolog Insulin 18 Units via Flex Pen subcutaneously (SC) and Baclofen 40 milligrams (mg) tablet by mouth (PO) at 1616, for Resident #102. Physician orders dated 2/28/15 and Medication Administration Record (MAR)	F 332	F332 POC accepted 5/20/15 MBertrand/RN/AMC  F 332. 483.25(m)(1)  Resident #102 had no negative effects as a result of the alleged deficient practice.  Residents requiring medications with meals residing in the facility have the potential to be affected by the alleged deficient practice.  Education will be provided to licensed staff on the procedure for medication administration.	

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C. 04/29/2015
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NAME OF PROVIDER OR SUPPLIER  DUNWAN COURT HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 378 PROSPECT STREET BARRE, VT 05641
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F 332	Continued From page 2 dated April 2015, evidences that Novolog Flex Pen Solution Pen-Injector 18 Units SC is to be administered with meals for Diabetes at 1700 (5 PM). Administer Baclofen Tablet 40 mg PO with meals for muscle spasticity at 1700.  Per interview with the RN on 4/27/15 at approximately 4:20 PM, confirmation was made that the medications were not administered with meals as per physician orders. Per observation on 4/27/15 at 4:55 PM Resident #102 had not received his/her evening meal.	F 332	Random audits will be conducted 3 times weekly by the DON or designee to monitor the effectiveness of the plan. The results of the audits will be reported to the QAA committee for three months at which time the QAA committee will determine the continued duration of audits.  Corrective action will be completed by 5/29/15.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked,	F 431	F332 POC accepted 5/20/15 M.Bertrand RN/PM  <hr/> F431 483.60(b),(d),(e)  No residents were negatively affected by this alleged deficient practice.  Residents with allergies residing in the facility have the potential to be affected by the alleged deficient practice.  The epinephrine has been replaced in the facility.	

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

FORM APPROVED  
OMB NO. 0938-0391

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F 431	<p>Continued From page 3</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to monitor the storage and timely replacement of expired epinephrine in two of two anaphylaxis emergency kits. Findings include:</p> <ol style="list-style-type: none"> <li>1. During observation of the medication storage room on Wing 2 at 8:30 AM on 4/29/15, the anaphylaxis (severe allergic reaction) emergency kit was found to contain an Epi 2 Pak kit (2 epinephrine injection pens). The kit was marked with an expiration date of 11/14. The Registered Nurse (RN) confirmed at 8:35 AM that the epinephrine in the emergency kit had an expiration date of 11/14.</li> <li>2. During observation of the medication storage room on Wing 1 at 8:55 AM on 4/29/15, the anaphylaxis emergency kit was found to contain an Epi 2 Pak kit containing two epinephrine injection pens. The kit was marked with an expiration date of 12/14. The RN confirmed at that time that the epinephrine in the emergency kit had an expiration date of 12/14.</li> </ol> <p>At 9:15 AM on 4/29/15 the nursing administration</p>	F 431	<p>A random audit will be conducted one time per week by the DON or designee to monitor the effectiveness of the plan. The results of the audits will be reported to the QAA committee for three months at which time the QAA committee will determine the continued duration of audits.</p> <p>Corrective action will be completed by 5/29/15.</p> <p><i>F431 POC accepted 5/29/15 M.Bertrand RN/PMC</i></p>	
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F 431	Continued From page 4 for the facility confirmed after consulting the pharmacy that epinephrine which is outdated has the potential to be less effective and that there were no other stores of epinephrine at the facility. Nursing administration provided the allergy list for residents which indicated that multiple current residents were listed as having allergies to food, environment (including bee sting), and medications. The written policy titled "Anaphylaxis Assessment and Treatment Kit" provided by the facility included the administration of Epinephrine Hydrochloride by injection in the event of symptoms of anaphylaxis.	F 431		
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 (3) Maintains a record of incidents and corrective actions related to infections.  (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	F 441	<div style="border: 1px solid black; padding: 5px;"> <p>F441 483.65</p> <p>Resident #119 had no negative effects as a result of the alleged deficient practice.</p> <p>Residents requiring contact precautions and enteral feeding have the potential to be affected by the alleged deficient practice.</p> <p>Education will be provided to staff regarding contact precautions.</p> <p>Education will be provided to licensed staff regarding Infection Control procedures for enteral feeding.</p> </div>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**ENTERS FOR MEDICARE & MEDICAID SERVICES**

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F 441	<p>Continued From page 5</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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 observation, interview and policy review, the facility failed to implement proper infection control measures to prevent spread of infection for one applicable resident in the survey sample. (Resident #119) Findings include:</p> <p>Per observation on 04/27/15 at 3:20 PM, the Registered Nurse (RN) failed to follow infection control measures for Resident #119 who was identified as being on contact precautions. The nurse gowned and gloved prior to entering the room and proceeded to provide nutrition through the use of a feeding tube via a feeding pump. While setting up the feeding pump, the end of the feeding tube fell on the floor. The RN picked up the tube, removed the end-cap and inserted the feeding tube into the resident's access tube (known as a J-tube). When the RN was finished, the nurse removed the gloves and gown but failed to use hand hygiene. The nurse went to the medication cart in the hall, arranging items on the cart and then used a hand sanitizer. The</p>	F 441	<p>Random audits will be conducted 3 times weekly by the DON or designee to monitor the effectiveness of the plan. The results of the audits will be reported to the QAA committee for three months at which time the QAA committee will determine the continued duration of audits.</p> <p>Corrective action will be completed by 5/29/15.</p> <p><i>F441 POC accepted 5/20/15 D. Bertrand RN/PMC</i></p>	
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F 441	Continued From page 6 nurse during interview at that time, was not aware that the feeding tube had landed on the floor and acknowledged that hand hygiene was not implemented prior to leaving the room. Per review of the facility's policy on 'Protocols' for Contact Precaution it states that gloves and gowns are to be removed, placed in a doubled bag and hands are to be cleaned prior to leaving the resident's room. Per interview that afternoon, the Unit Manager acknowledged that the feeding tube should've been sanitized prior to insertion and confirmed that hands should be sanitized and or washed prior to leaving the resident's room.	F 441		