

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

January 12, 2015

Mr. Larry Goetschius,  
Addison County Home Health & Hospice Inc  
Po Box 754  
Middlebury, VT 05753-0754

Dear Mr. Goetschius:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 2, 2014**. 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

PRINTED: 10/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  477014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/02/2014
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NAME OF PROVIDER OR SUPPLIER  ADDISON COUNTY HOME HEALTH & HOSPICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 754 MIDDLEBURY, VT 05753
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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
G 109	Continued From page 1 services or changes.	G 109		
G 158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that the written plan of care was established and periodically reviewed by a physician for 3 of 20 patients sampled ( Patients #1, 2, and 4): Findings include:</p> <p>1. Per record review on 9/30-10/1/14, Patient #1 was admitted to agency services to receive skilled nursing on 5/14/14. Per review of the certification period from 7/13/14 to 9/10/14, the plan of care for 7/13/14 - 9/10/14 was not signed by the MD until 9/30/14; after the lack of a signature was pointed out by the surveyor. The agency obtained a signed plan of care with the MD signature dated 9/30/14, which was 20 days after the end of that 60 day certification period. Per interview on 9/30/14 at 9:50 AM, the Director of Clinical Services confirmed that the plan of care for the certification period 7/13/14 - 9/10/14 was not signed by the physician until 9/30/14.</p> <p>2. Per record review on 10/1 - 10/2 14, Patient #1 had a verbal order form dated 6/6/14 that was generated in the certification period of 5/14 -7/12/14 requesting signed orders for skilled nursing that stated the frequency of visits. The MD had signed the verbal order on 6/13/14, however the form was not signed by the nurse</p>	G 158	See Attached	

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G 158	Continued From page 2 who took the order, and was only stamped with an agency name and address in the space where the nurse would sign their name. Per interview on 10/2/14 at 9:30 AM, the Director of Clinical Services confirmed that the expectation was that the nurse use her signature at the bottom, and that an agency stamp was not an acceptable substitute for the clinician's signature.  3. Per record review on 09/29/14, Patient #4 was referred on 08/14/14 for Home Health services and admitted on 08/15/14. There is no documentation that the physician was aware of treatment modalities or frequency of services prior to the signed orders. Additionally, the 485 (care plan/ physician order) was not signed until 09/29/14. Per interview on 10/01/14 at 10:30 AM the Clinical Director "I don't see that we let the doctor know of the plan" and confirmed the above findings.	G 158			
G 170	4. Per record review on 10/1/14, Patient #2 was admitted to skilled nursing services for surgical aftercare on 8/24/14. Per review of the plan of care, there was not a returned signed order copy as yet available for this patient. There were no signed orders for type of dressing, frequency of dressing change, nor goals related to healing of wound. The frequency of nursing visits also did not have a signed order. On 10/1/14, the Director of Clinical Services produced a 485 for this patient that had been signed by the MD on 9/30/14. The Director also confirmed that there were no other signed treatment or frequency orders done up to this point for Patient #2. 484.30 SKILLED NURSING SERVICES  The HHA furnishes skilled nursing services in	G 170	See Attached		

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G 170	<p>Continued From page 3 accordance with the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency did not furnish skilled nursing services in accordance with the plan of care for 3 of 20 patients sampled (#6, 5, and 7) Findings include:</p> <p>1. Per review on 09/30/14 Patient #5 was admitted on 09/17/14 with diagnosis of Congestive Heart Failure (CHF), Renal Failure, Hypertension, and Anemia. The nurses failed to assess the oxygen levels ( O2 saturation= O2 sats) as ordered. The Physician's referral order dated 09/16/14 requests monitoring of breathing, the use of oxygen and the need to "assess O2 sats on RA (room air)". The initial nursing visit notes on 09/17/14 shows the nurse assessed the O2 sat levels with oxygen and on room air, however on September 19th, 23rd, 24th, and 26th presents the nurse assessed the O2 sats while the patient was using oxygen. The Clinical Manager on 10/02/14 at 12:36 PM confirmed the nurses did not follow the physician's order to assess the oxygen levels on room air.</p> <p>2. Per record review on 10/1/14, nursing failed to provide a weekly visit as ordered for Patient #7 who had multiple co-morbidities such as cardio-vascular disease, CHF, anxiety, anemia and atrial fibrillation. Per the 485 (Order/care plan) dated 09/03/14 - 11/01/14, directs the nurse to make 1-3 visits per week. The nurse did not make a visit from 09/03 - 09/12, 9 days later. The Clinical Manager stated on 10/01/14 at 4:26 PM that the nurse may have been messed up by</p>	G 170	See Attached	

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G 170	Continued From page 4 the certification survey and confirmed the nurse did not make the weekly visit.  3. Per medical record review and confirmed by Clinical Manager during interview on 10/02/2014 at 11:25 AM, the agency failed to make skilled nursing visits to client # 6 within the ordered frequency. This client had physician orders on 08/26/2014 that read "change skilled nursing visits to 1-2 x/ every 14 days x 60 days." The first visit made to this client was 17 days after the order was changed. Visits were documented as having been made on 08/22/2014 and the next one made was 09/12/2014.	G 170			
G 212	484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAINING  The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.	G 212	See Attached		
	This STANDARD is not met as evidenced by: Based on record review and staff interview, the home health agency failed to ensure that 2 of 6 staff members reviewed had met the competency requirement as to their delivery of care to agency clients.  Per review of staff employee records on 10/02/2014 and confirmed by staff during interview on that day at 2:30 PM, 2 staff members had no documentation for having competencies completed. Annual evaluations of 2 LNAs have not been signed by the employees. Staff indicate that they receive supervision of delivery of care done on mannequins. Administrative staff report				

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G 212	Continued From page 5 that only trainings are done on the mannequins and that actual care is done on each other.	G 212	See Attached		
G 230	484.36(d)(3) SUPERVISION  If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.  This STANDARD is not met as evidenced by: Based on record reviews and confirmed by interview the Registered Nurse [RN] failed to supervise LNA [licensed nursing assistants] and/or PCA (personal care attendants) for 2 of 5 patients receiving unskilled services (Patient # 3 and # 5). Findings include:  1. Per review of the medical record for Patient #3 on 09/29/14, the RN did not supervise the PCA as required every 60 days when receiving unskilled services for greater than one year. Per review a Licensed Social Worker [LicSW] was making visits. This is confirmed by the Case Manager during interview on 08/20/2014 at 4:20 PM.  2. Per record review on 08/18/14, Client #4 did not receive supervisory visits as required every 60 days for PCA unskilled visits. There were no supervisory visits made by . Per interview on	G 230			

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G 230	Continued From page 6 08/20/14 at 4:03 PM the Long Term Care Coordinator confirmed the required 60 day supervision visits were not made.	G 230			
G 236	484.48 CLINICAL RECORDS  A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.  This STANDARD is not met as evidenced by: Based on record review and interview the Agency failed to maintain the clinical records that contains pertinent patient information consistently and accurately in accordance with accepted professional standards for 3 of 20 patients (Patients #8, 9, and 10). Findings include:  1. Per the record review on 09/29/14, Patient #9's record contained inaccurate information on the care plan/ physician's order, known as the 485. The current 485 dated 09/11/14 - 10/19/14 shows home health aide services 1-2 times a week. However, services were discontinued per the patient's request on 08/22/14 and the physician was notified prior to this recertification period. Per interview on 10/02/14 at 1:41 PM the Clinical Director confirmed Patient #9's record contained	G 236	See Attached		

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G 236	<p>Continued From page 7 inaccurate information.</p> <p>2. Patient #10's record failed to show current and correct information. Per request on 09/29/14 at 9:15 AM for current patients using electronic medical records (EMR), Patient #10 was listed as 'open' meaning currently receiving services. The record showed the patient receiving weekly nursing services until 08/30/14 when the patient went to the hospital. There is no further information as to the status of the patient or if the patient has been discharged. Per interview on 10/01/14 at 3:57 PM the Clinical Educator stated that the patient had died in the hospital after the transfer and confirmed the failure of a nursing discharge note or the closure of the record.</p> <p>3. Per observation in the client's home and per record review on 09/29/2014, the information on the in-home care plan does not match the orders for Client # 8 as written on the 485. The orders that are written on the 485, signed by the physician and present in the permanent record indicate that the client is to have a complete or partial bed bath. S/he is actually getting in and out of a walk-in tub with assistance of 1 LNA. The care plan in the home, updated on 05/28/2014 does reflect the care provided to the client. This is confirmed by staff during interview on 10/02/2014 at 11:50 AM.</p>	G 236		

# Plan of correction

Survey 10/2/14

Tag Number	Regulation
1. G 109	<p><b>CoP 484.1(c)(2): Right to be informed and to participate in planning care and treatment.</b></p> <p><b>G 109:</b> The patient has the right to participate in the planning of the care. The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p>
<b>Plan of Correction</b>	
<b>What action you will take to correct the deficiency?</b>	
<p>The issue of consent for services was discussed by the Interim Clinical Director with all clinical staff present during a Staff Conference held on 10/22/2014. Staff received training regarding the role of guardians in participating in and planning for a patient's care. Clinical staff who were not present at the Staff Conference will receive a copy of the Staff Conference Minutes/handouts, and will sign/date to confirm that they have received and reviewed the information.</p> <p>The Interim Clinical Director reviewed:</p> <ol style="list-style-type: none"> <li>1. When a patient cannot sign for his/her own care and has a guardian, that guardian acts as the patient and has the responsibility to act on and participate in the planning of the care.</li> <li>2. It is the guardian's responsibility to make all decisions regarding medical care.</li> <li>3. Clinicians must obtain consent from the guardian prior to admission, for all procedures, and for any/all changes in care/service and are responsible for signing consent and discharge forms.</li> <li>4. Coordination of care is to occur with the guardian prior to any changes in the plan and is to be documented in the patient's record.</li> </ol>	
<b>What Measures will be put into place or what systematic changes you will make to assure that the deficient practice does not recur?</b>	
<p>All patients who have a guardian will have their charts labeled:</p> <ol style="list-style-type: none"> <li>1. The patient's permanent medical records and the travel record will receive a yellow label. The label will identify that the patient has a guardian, their name, and contact information.</li> <li>2. Contact information guardians will be entered in the patient's profile in Mckesson Clinical Explorer.</li> </ol>	
<b>How the corrective actions will be monitored so the deficient practice does not recur?</b>	
<ol style="list-style-type: none"> <li>1. All current patients will be reviewed to identify those who have guardians. Their charts will be labeled according to above described procedure.</li> <li>2. Record audits will be performed to determine compliance with standard.</li> </ol>	

*Rec'd  
1-8-15  
RC/SS*

# G 109 - 1. labels for charts

Guardian

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

## Plan of correction

Survey 10/2/14

Tag Number	Regulation
2. G 158	<p><b>CoP 484.18 Acceptance of patients, plan of care, and medical supervision.</b>  <b>G158:</b> Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopath, or podiatric medicine.</p>
<b>Plan of Correction</b>	
<b>What action you will take to correct the deficiency?</b>	
<p>1. Regarding absence of and/or late Plans of Care (P.O.C.)/signed orders. Tracking systems which are currently in place have been reviewed and are being strengthened as follows:</p> <p style="margin-left: 20px;">a. Once a patient has been admitted, Physician Interim Orders are sent to the MD of record for confirmation and signature. This occurs within 5 (five) days of the admission visit. The <u>Visit Frequency and Duration</u> has been added to this Physician Interim Order form.</p> <p style="margin-left: 20px;">b. The Interim Clinical Director and the Team Leaders are notified weekly (by the Business Office Manager) of Plans Of Care which are pending for new admissions. The goal will be to have the Plan of care completed and sent to the physician as soon as possible after the admission visit.</p> <p>2. The issue of absent and late written plans of care was discussed by the Interim Clinical Director with all clinical staff present during the Staff Conference on 10/22/2014. Clinical Staff who were not present at the Staff Conference will receive a copy of the Staff Conference Minutes/handouts, and will sign/date to confirm the have received and reviewed the information.</p> <p>3. Regarding the use of an agency stamp and address in place of a signature. This is an unusual occurrence and not acceptable. A clinician's signature has always been expected and is expected on any order. No order will leave the agency without a clinician's signature.</p>	
<b>What Measures will be put into place or what systematic changes you will make to assure that the deficient practice does not recur?</b>	
<p>1. The notification list, sent to the Interim Clinical Director and the Team Leaders, will be reviewed by the Interim Clinical Director and the Team Leaders. Team leaders will discuss the pending written plans of care with those clinicians and assist them in expediting the completion.</p> <p>2. All verbal orders sent to the physician for confirmation (via mail or fax) will be checked prior to leaving the building by a clerical staff person to insure that each order has been signed by a clinician.</p>	
<b>How the corrective actions will be monitored so the deficient practice does not recur?</b>	
<p>1. The list of pending/late P.O.C. will decrease in number.</p> <p>2. Record Audits will be performed to determine compliance with the standard.</p>	

POC amb  
 1-8-15  
 K/SL

G158a

Phone: (802) 388-7259 Addison County Home Health and Hospice, Inc.  
 Interim Physician Orders Fax: (802) 388-6126

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Admitting Clinician: \_\_\_\_\_  
 SOC/RESUME DATE: \_\_\_\_\_  
 The following are the CMS identified parameters which require on-going physician-clinician collaboration. Visit Frequency and Duration: \_\_\_\_\_  
 This information will be again confirmed on the formal plan of care.

YES	NO	N/A	Vital Signs	Patient Specific Parameters	Additional Specific MD Parameters
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vital signs to report to MD	~ Temperature + 100.5 ~ Pulse: -60 +120 ~ Respiration: -12 +28 ~ O2 Sat: -90% ~ BP: Systolic: -90 + 150 Diastolic: -50 + 90 ~ Weight increase of 2-3 lbs in one day OR ~ Weight increase of 4-5 lbs in past 5 days	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Diabetic Foot Care	~ Monitor blood sugars ~ Assess lower extremities, condition of skin ~ Teach s/s hypo/hyperglycemia ~ Teach insulin administration, if needed ~ Teach s/s of UTI ~ Teach importance of exercise ~ Notify MD when BS - 50 BS +150 ~ Teach/provide diabetic foot care ~ Teach disease process ~ Teach s/s of infection ~ Assess nutritional status ~ Teach diet	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fall Prevention	~ Teach safety factors ~ Teach appropriate footwear ~ Assess assistive devices ~ Teach fall prevention ~ Adapt patient's environment - lighting, grab bars, etc. ~ Teach wide base when standing ~ Teach avoid quick change in position ~ Referral to physical therapy	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	~ Assess each visit - affect, social interaction, functional level ~ Monitor medications - assess response to medications ~ Teach re: medications actions, uses, side effects ~ Teach re: s/s depression - flat affect, withdrawn, changes in personal hygiene	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Management	~ Assess pain each visit, rate ~ Teach balance of rest/activity ~ Teach medications - actions, uses, side effects ~ Assess response to medications, compliance ~ Teach when to call RN/MD- increased pain, change in type of pain.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pressure Ulcer Prevention/Treatment	~ Assess skin each visit ~ Assist with pressure relieving devices ~ Teach importance of limiting moisture ~ Teach active/passive ROM ~ Assess nutritional status ~ Teach use of protective undergarment if incontinent ~ Teach skin care, q2-4hr, change of position ~ Teach adequate fluid intake ~ Teach s/s of infection - fever, odor, drainage ~ Teach adequate nutrition ~ Wound care consult if needed	

## Plan of correction

### Survey 10/2/14

Tag Number	Regulation
3. G 170	<p><b>CoP 484.30: Skilled Nursing Services</b>  <b>G 170:</b> The HHA furnishes skilled nursing services <i>in accordance with the plan of care.</i></p>
<b>Plan of Correction</b>	
<b>What action you will take to correct the deficiency?</b>	
<p>Furnishing skilled nursing services in accordance with the plan of care was discussed by the Interim Clinical Director with all clinical staff during the Staff Conference on 10/22/2014. Staff received training regarding following the written and signed plan of care. The physician has ordered and signed the orders and we MUST follow them as ordered. If there is a change in status or other reason why the written and signed orders can not be followed the RN is required to contact the physician and get the orders changed. This is not a new regulation and one that needs to be followed with no exceptions. Clinical staff who were not present at the Staff Conference will receive a copy of the Staff Conference Minutes/handouts, and will sign/date to confirm the have received and reviewed the information. The Interim Clinical Director reviewed:</p> <ol style="list-style-type: none"> <li>1. Failing to assess the oxygen level. Reviewed with clinicians the deficiency and discussed how the specific physician's order for assessing O2 Sats on room air was only documented on the admission visit. The following visits the nurse documented O2 Sats while on O2 only. Discussed that the clinician is responsible for following physician orders.</li> <li>2. Failing to provide a weekly visit when P.O.C. has orders for skilled nursing visits 1-3x/week. Reviewed the deficiency and discussed with staff frequency discrepancies. Discussed that a week is considered 7 days from the last visit. Examples of how to count visit frequencies were discussed with staff.</li> </ol>	
<b>What Measures will be put into place or what systematic changes you will make to assure that the deficient practice does not recur?</b>	
<p>1 &amp; 2.</p> <ol style="list-style-type: none"> <li>a. Charts reviews to identify any orders and visit frequencies that are not in accordance with the plan of care.</li> <li>b. Additional education for individual clinicians will occur when chart reviews have identified orders or frequencies which have not been met per the P.O.C.</li> </ol>	
<b>How the corrective actions will be monitored so the deficient practice does not recur?</b>	
1 & 2. Record Audits will be performed to determine compliance with the standard.	

Prepared  
 10/8/14  
 KCL

# Plan of correction

Survey 10/2/14

Tag Number	Regulation
4. G 212	<p><b>CoP 484.36(b)(1): Competency evaluation and in-service training</b>  <b>G 212:</b> The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p>
<b>Plan of Correction</b>	
<b>What action you will take to correct the deficiency?</b>	
<ol style="list-style-type: none"> <li>1. In reference to the 2 staff member that you reported had no documentation for competencies completed, upon review of their Human Resource Records and as explained during the survey these two employees were hired as Personal Care Attendants (PCAs) and not as LNAs. They DO NOT and NEVER have performed LNA duties. We have NEVER submitted any bills reflecting visits or care performed as a LNA. These two particular employees have LNA licenses but are not hired as LNAs and nor do they work for us as LNAs. The agency has no responsibility to provide competencies for them because their license is not related to their job description or their expected performance. It would be no different than an RN hired as a filing clerk. The fact that they had an RN license would not pertain to their specific job requirements so the agency would have no responsibility for that RN to do competencies etc related to that license. PCAS do not require licenses.</li> <li>2. Annual evaluations of two LNAs had been discussed and reviewed with the LNA but had not been signed by the employee. Record reviews of LNA annual evaluations will be performed by the Home Health Aide Supervisor. Any annual evaluations that are not signed by the employee will be signed by the employee.</li> <li>3. Upon review with the Home Health Aide Supervisor and Interim Clinical Director, direct supervision of delivery of care is only done on patients and not on mannequins. Only some LNA trainings and perineal care trainings are done on mannequins. The review of skills has always and will continue to be done with each patient when a nurse introduces an LNA into a new patient care situation or during a supervisory visit. The periodic review of skills takes place with patients or with live staff. New trainings and skills may be demonstrated on mannequins but tested on live staff.</li> </ol>	
<b>What Measures will be put into place or what systematic changes you will make to assure that the deficient practice does not recur?</b>	
<ol style="list-style-type: none"> <li>1. Human Resources will not maintain records of LNA licenses for employees who have an active LNA license but are employed by our agency as a PCA. A license is not needed. This is apparently causing confusion and misunderstanding upon survey.</li> <li>2. Human Resources will review LNA annual evaluations for employee signatures prior to filing in the HR record.</li> <li>3. a. <u>Home Health Aid Performance Evaluation Visits</u> will include the patient's name (directly below the date of supervision).  b. <u>HHA Teaching Sheet / In-Service Documentation</u> will continue to be used by skilled nursing and physical therapy to document training. This documents direct care and is specific to both the patient and home health aide.</li> </ol>	
<b>How the corrective actions will be monitored so the deficient practice does not recur?</b>	
<ol style="list-style-type: none"> <li>1. &amp; 2. Human Resources Record audits will be performed to determine compliance with standard.</li> <li>3. The Home Health Aide Supervisor will assure that only training of skills is done on a mannequin as needed, but testing is done on a live staff member. LNA supervision of the delivery of care will be documented to include the patient's name.</li> </ol>	

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ADDISON COUNTY

# HOME HEALTH & HOSPICE

## Home Health Aide Performance Evaluation Visits

Employee Name: \_\_\_\_\_

Date of Hire \_\_\_\_\_

Supervisor: \_\_\_\_\_

Date and Code appropriate boxes (Scale 1-5)

Date of Supervision				
<b>Personal Care</b>				
<i>Add → Patients Name</i>				
Total Bed Bath				
Assist. Bed Bath				
Tub Bath				
Shower				
Hair Care				
Skin Care				
Oral Care				
Shave				
Change Bed				
Dressing				
Assist. With Dressing				
Other:				
<b>Elimination</b>				
Bed pan/urinal				
Bedside Commode				
Empty Drainage Bag				
Catheter Care				
Perineal Care				
Other:				
<b>Activity</b>				
Position				
Transfer				
Assist. With Ambulation				
Supervise Ambulation				
ROM Exercises				
Body Mechanics				
Other:				
<b>Health and Safety</b>				
Clean work area				
Infection Control				
Meal Prep				
Feeding				
Other:				





## Plan of correction

Survey 10/2/14

Tag Number	Regulation
5. G 230	<p><b>CoP 484.36(d)(3): Supervision (home health aide).</b>  <b>G 230:</b> If the home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the <b>Registered Nurse</b> must make a supervisory visit to the patient's home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p>
<b>Plan of Correction</b>	
<b>What action you will take to correct the deficiency?</b>	
<p>For clarification purposes, the patients in question were receiving PCA services only, not LNA services. Choices for Care Coordinator (CFC), June Glebus, RN scheduled a meeting on 10/2/14 with all CFC Case Managers. The meeting was held to review the regulation requirements for supervision of an LNA and/or PCA. The CFC Coordinator reviewed the regulation. If LNA and/or PCA services are provided to a patient who is not receiving SN, PT, OT, or SLP services an RN, not a Licensed Social Worker, must make the supervisory visit to the patient's home no less frequently than every 60 days. Copies of the regulation were distributed to all CFC Case Managers. It is unclear that PCA supervision must be done by an RN. The regulation specifically states a home health aide who is a licensed LNA and who does require RN supervision. A PCA is not licensed and works only under the supervision of the CFC case manager under the Choices for Care Program. We are happy to comply with this interpretation however.</p>	
<b>What Measures will be put into place or what systematic changes you will make to assure that the deficient practice does not recur?</b>	
<p>1. The CFC Coordinator will schedule an RN to make the supervisory visits for PCAs when the CFC Case Manager has a Masters of Social Worker degree.</p>	
<b>How the corrective actions will be monitored so the deficient practice does not recur.</b>	
<p>Record Audits will be performed to determine compliance with the standard.</p>	

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# Plan of correction

Survey 10/2/14

Tag Number	Regulation
6. G 236	<p><b>CoP 484.48: Clinical Records</b>  <b>G 236:</b> A clinical record continuing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders, signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and discharge summary.</p>
<b>Plan of Correction</b>	
<b>What action you will take to correct the deficiency?</b>	
<p>The standard for Clinical Records was discussed by the Interim Clinical Director with all clinical staff during the Staff Conference on 10/22/2014. The Clinical Director reviewed the regulation and deficiencies and provided education about the standards for Clinical Records, specifically that if services are discontinued then the plan of care must accurately reflect that. When LNAs, in particular, are discontinued by patient desire or by clinician when goals are met then an order must be signed by physician to confirm that orders are discontinued. And those orders must then be removed from the next plan of care.</p> <p>Clinical Staff who were not present at the Staff Conference will receive a copy of the Staff Conference Minutes/handouts, and will sign/date to confirm they have received and reviewed the information.</p>	
<b>What Measures will be put into place or what systematic changes you will make to assure that the deficient practice does not recur?</b>	
<p><b>1. &amp; 3.</b> Patients Record Containing inaccurate information on the care plan / 485.            As already instituted, two weeks prior to the end of a patient's home health certification period clinician's will receive a paper copy of the current plan of care / 485 to review for accuracy. Clinician's will review the plan of care for accuracy. The clinician will make changes on the paper copy to assure that changes in orders/care are accurate for the new Plan of care/485 (recertification).</p> <p><b>2.</b> Patient's record failed to show current and correct information.            Education has been provided to Clinicians and Team Leaders on the importance of updating clinical records promptly.</p>	
<b>How the corrective actions will be monitored so the deficient practice does not recur?</b>	
<p><b>1, 2, &amp; 3.</b> Record audits will be performed to determine compliance with standard.</p>	

*MOC audit  
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