

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

November 30, 2012

Meg Baldor, Administrator
Caledonia Home Health Care
161 Sherman Drive
Saint Johnsbury, VT 05819-1146

Provider ID #:477010

Dear Ms. Baldor:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 5, 2012**.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

PRINTED: 11/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2012
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE SAINT JOHNSBURY, VT 05819		
(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 000	INITIAL COMMENTS	G 000			
G 170	<p>484.30 SKILLED NURSING SERVICES</p> <p>The HHA furnishes skilled nursing services in 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 failed to furnish skilled nursing services in accordance with the plan of care for 1 applicable client. (Client #1) Findings include:</p> <p>Per record review on 11/05/12 for Client #1, the physician ordered (on 09/17/12) nursing visits to assess for comfort medication use/effects, mental status disorder and fatigue. Per record review, nursing and social worker were made aware of the client's statement on 09/26/12, to another staff member, about suicidal ideation. A social service note on 09/27/12 states "will contact CRT next week on Tuesday". On 10/01/12 a nursing note states "nursing attempts to call client, refused nursing visit not feeling well". There is no documentation if an assessment was completed or what interventions were implemented. Review of the Agency's Procedures for Suicide statements indicates that interventions and assessments are needed. Per interview on 11/05/12 at 2:15 PM the Clinical Manager stated that "when the Agency first heard about this [that day] I instructed the nurse to notify APS and started working with the doctor and with the mental health worker, I was assured</p>	G 170	<i>Please see attached Plan of Correction</i>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Margaret Balala, RN

TITLE

Director

(X6) DATE

11/28/2012

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 80 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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G 170	Continued From page 1 [the client] was not in danger." However, he/she confirmed that there is nothing written to verify what was said, how client was safe, the interventions or an assessment.	G 170			
G 196	Also see G-196 484.34 MEDICAL SOCIAL SERVICES The social worker participates in the development of the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview the social worker failed to participate in the development of additions and/or to the plan of care for 1 applicable client. (Client #1) Findings include: 1. Per record review on 11/05/12 for Client #1, the social worker was made aware of the client's statement on 09/26/12, to another staff member, about suicidal ideation. A social service note on 09/27/12 states 'will contact CRT [crisis team] next week on Tuesday'. The call log dated 10/2/12 states "left message with MD updating [client's] physical and emotional and suicidally 'did not have a detailed plan but made it clear that s/he has lots of narcotics available, advised to access the emergency room, s/he is reluctant to do so'. There is no further communication as to changes, additions, or interventions on the care plan. Per interview on 11/05/12 at 2:15 P.M. the Agency's Director stated that the expectation and per Agency's Policy is that the client be assessed and implement interventions with noted changes on the care plan. S/he also stated the social worker is able to make changes to the care plan but confirmed that no additions to care plan were	G 196	<i>Please see attached Plan of Correction.</i>		

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G 196	Continued From page 2 made. also see G-170	G 196		

Caledonia Home Health & Hospice
Plan of Correction for Survey completed 11/05/2012

G170: CHHC has reviewed and revised its policy and procedures for suicide risk prevention across all programs.

This policy and procedure is pending Board approval and once approved, it will be forwarded to the Division of Licensing and Protection before 12/31/2012.

All staff will receive training to our new policy and procedure that includes:

- recognition of a patient's safety risk according to VNAA Clinical Guidelines for Behavioral Health, Suicide Risk Factors;
- use of PHQ-9 screening tool and corresponding documentation of patient safety;
- appropriate referral of client;
- documentation of referral and follow-up response from appropriate referrals made to human services, mental health, physicians/providers.

Professional staff training will be completed in December 2012, and paraprofessional and non-professional staff training will be completed in January 2013. Training to this policy/procedure will be administered annually to all staff.

POC ACCEPTED 11/29/12 Susan L. Emmons RN

G196: CHHC has reviewed and revised its policy and procedures for suicide risk prevention across all programs.

This policy and procedure is pending Board approval and once approved, it will be forwarded to the Division of Licensing and Protection before 12/31/2012.

All staff will receive training to our new policy and procedure that includes:

- recognition of a patient's safety risk according to VNAA Clinical Guidelines for Behavioral Health, Suicide Risk Factors;
- use of PHQ-9 screening tool and corresponding documentation;
- appropriate referral of client;
- follow-up response from appropriate referrals made to human services, mental health, physicians/providers.
- Medical Social Workers will document changes and/or additions of interventions to the Plan of Care appropriately.

Professional staff training will be completed in December 2012, and paraprofessional and non-professional staff training will be completed in January 2013. Training to this policy/procedure will be administered annually to all staff.

CHHC's QAPI Committee will monitor the effective use of this policy/procedure across all programs.

POC ACCEPTED 11/29/12 Susan L. Emmons RN