

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

May 2, 2013

Renee Kilroy, Administrator
Caledonia Home Health Care
161 Sherman Drive
Saint Johnsbury, VT 05819

Provider ID #:471502

Dear Ms. Kilroy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 9, 2013**.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2013
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NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE SAINT JOHNSBURY, VT 05819
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L 000	INITIAL COMMENTS	L 000		
L 541	<p>418.56(a)(1)(i)-(iv) APPROACH TO SERVICE DELIVERY</p> <p>The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:</p> <p>(i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice). (ii) A registered nurse. (iii) A social worker. (iv) A pastoral or other counselor.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, the agency failed to have a medical doctor present at all the interdisciplinary group (IDG) meetings for 8 of 11 sampled records. (Patients #1, #2, #3, #4, #6, #7,8,9). Findings include:</p> <p>1) Per review of the electronic medical record [EMR] for Patient# 3 on 04/09/2013 at 10:30 am, there is no documentation to support that the medical doctor was present at the 10/30/2012 IDG meeting or any in November 2012 (except 11/06/2012). Staff confirm during interview on 04/09/2013 that there is no evidence in the medical record to indicate that a physician was present at the weekly IDG meetings. Further, the staff report that there is no current way to capture the full attendee list in the agency's EMR and that</p>	L 541	<p>The IDG has a designated Medical Director, who is integrally involved in all patient plans of care. We acknowledge that the hospice Medical Director was not in attendance at some of the cited IDG meetings. However, the Medical Director was always available by phone for changes to plans of care if necessary. To remediate, staff have been trained on how to capture the full IDG attendee list within the medical record and implementation has begun. Documentation on phone participation by the Medical Director will be documented. This process will be monitored by the Hospice Director (or in the absence of the Hospice Director, the meeting lead designee) during every weekly IDG meeting. Completeness and accuracy will be verified by the Hospice Director weekly.</p> <p><i>5/2/13</i> <i>POC accepted SEminons RV/FKelle</i> <i>RV HSN/DBA</i></p>	4/10/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Margaret T. Bullock, RN</i>	TITLE <i>Director, Caledonia HH-H</i>	(X6) DATE <i>4/26/13</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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L 541	<p>Continued From page 1</p> <p>written minutes are not kept for every meeting.</p> <p>2) Per review of the EMR for Patient # 4 on 04/08/2013 at 2:30 P.M., there is no documentation to support that the medical doctor was present at the 01/22/2013, 01/29/2013 or the 02/05/2013 IDG meeting. Staff confirm during interview that there is no electronic evidence to indicate that the physician attended the weekly IDG meetings. But the staff was able to produce the written minutes for the 01/22/2013 and 01/29/2013 meetings and these indicate that the physician was present for those 2 meetings.</p> <p>3) Per record review on 04/08/2013 at 3:00 P.M. for two current patients, Patient # 1 who was admitted on 03/08/13 and Patient #6 admitted on 03/20/13 there is no documentation to support that the medical doctor was present at the IDG meetings. Per review of the EMR IDG meeting notes the medial doctor is not in attendance on March 19th, 26th IDG meeting for Patient #1 and on March 26th for Patient #6. Staff confirm during interview on 04/09/2013 at 3:30 P.M. that there is no evidence in the EMR to indicate that a physician was present at the weekly IDG meetings. Further, the staff report that there is no current way to capture the full attendee list in the agency's electronic medical record and that written minutes are not kept for every meeting.</p> <p>4) Per record review of Patient #2's closed record, there is no evidence that a medical doctor was in attendance during the weekly IDG meetings. Patient #2 was admitted on 10/09/12 and there is no evidence via the EMR notes nor hard copy notes of a medical doctor being present from October 16th through December 18,</p>	L 541		

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L 541	<p>Continued From page 2</p> <p>2012. The Hospice Director stated that "I am sure the doctor was there but not sure why it is not in the EMR" Upon review of the hard copy notes from this time period the Hospice Director stated that "these are the only copies we have and we're not sure all the people who where there are even listed. S/he confirmed that there is no evidence of the doctor being present at those meetings.</p> <p>5) Per closed record review on 04/08/2013 at 2:45 PM, Patient # 7 was admitted on 07/20/12. There is no documentation to support that the medical doctor was present at the IDG meeting on 8/21/12. Per review of the EMR and hard copy IDG meeting notes, there was no evidence that confirmed the doctor's presence at the meeting. On 04/09/2013 at 3:30 P.M., staff confirmed that there is no evidence in the EMR or hard copy notes to indicate that a physician was present at the weekly IDG meeting.</p> <p>6) Per closed record review on 04/08/2013 at 3:45 PM, Patient # 8 was admitted on 11/05/12, and discharged on 1/09/13. There is no documentation to support that the medical doctor was present at the IDG meetings on 11/06/12, 11/13/12, 11/27/12, 12/11/12, 12/18/12, 12/26/12, 1/02/13, or on 1/08/13. Per review of the EMR and hard copy IDG meeting notes, there was no evidence that confirmed the doctor's presence at the meetings. On 04/09/2013 at 3:30 P.M., staff confirmed that there is no evidence in the EMR or hard copy notes to indicate that a physician was present at the weekly IDG meeting, and that attendance roster and notes were not consistently and correctly documented.</p>	L 541		

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L 541	Continued From page 3 7) Per record review on 04/08/2013 at 2:00 PM, Patient # 9 was admitted on 3/18/13. There is no documentation to support that the medical doctor was present at the IDG meetings on 3/19/13, 3/26/13, or on 4/02/13. Per review of the EMR and hard copy IDG meeting notes, there was no evidence that confirmed the doctor's presence at the meetings. On 04/09/2013 at 3:30 P.M., staff confirmed that there is no evidence in the EMR or hard copy notes to indicate that a physician was present at the weekly IDG meetings to discuss this patient.	L 541		
L 545	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: This STANDARD is not met as evidenced by: Based on record review and staff interview the Hospice failed to develop an individualized plan of care that included all services necessary for the palliation and management of the terminal illness and related conditions for 1 of 2 applicable clients at the residency (Client #1) Findings include: 1. Per review of the care plan on 04/08/13 at 12:30 P.M. for Resident #1, who is currently living at a nursing home (N.H.), the care plan does not contain the current medication nor other	L 545	Agency will conduct case review of all patient plans of care where patients are cared for in a setting such as nursing homes, rehab centers where facility plans of care must be integrated into hospice plans of care. All inconsistencies will be resolved. Hospice Director will meet with Directors of Nursing for each facility where Caledonia Home Health & Hospice patients are being served to discuss strategies for plan of care integration and procedure to address/ resolve any questions or issues. Plans of Care will be addressed at weekly IDG meetings to ensure ongoing consistency and quality.	5/31/2013

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L 545	Continued From page 4 services provided by the nursing home staff. In addition the N.H.'s care plan does not have Hospice specific interventions or end of life concerns. Per record review on 04/08/13 the Resident's care plan dated 02/11/13 states areas of concerns, treatments, and assistance as needed by the N.H. staff, however does not contain the Hospice specific areas. Review of the 485 dated 03/08/13 states Fentanyl patch 50 mcg and Morphine Sulfate however the resident is currently receiving Fentanyl Patch 75 mcg and Oxycodone 5 mg three times a day as needed. Additionally this 485 does not address the type of assistance being given by the N.H.. Per interview on 04/08/13 at 1:00 P.M. the N.H.'s staff nurse confirmed that the Hospice nurse did not sign a new Hospice care plan and the 485 contained incorrect information. Per interview on 04/09/13 at 2:00 P.M. the Hospice Director stated that the nurse should review with the N.H. the care plan and confirmed that the care plan did not contain all services necessary for the palliation and management of the terminal illness and related conditions.	L 545		
L 620	418.76(d) IN-SERVICE TRAINING A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. This STANDARD is not met as evidenced by: Based on personnel record reviews and staff interviews, the hospice failed to ensure that hospice aides receive a minimum of 12 hours of in-service training during each 12-month period for 3 of 6 employees sampled. The specifics are as follows:	L 620	Agency will review training logs on a quarterly basis to assure the standard of 12 hours of in-service training is met for all hospice aides. This will be monitored during the quarterly Peer Review process as well as the routine staff meetings with aides' supervisor.	8/30/2013

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L 620	Continued From page 5 Per review of 6 employee personnel files, hired at various times, there is no record for 3 of them having had 12 hours of in-service training during a 12 month period. Staff # 1 had no inservices for the year 2012 (was hired in 2005), and has 5.48 hours documented so far for 2013. Staff # 2 has 4.43 hours of inservice for 2012. And Staff # 3 has 10 hours of inservice documented for 2012. These documented hours are confirmed during interview with human resource administrative staff on 04/09/2013.	L 620		
L 632	418.76(h)(2) SUPERVISION OF HOSPICE AIDES (2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care. This STANDARD is not met as evidenced by: Based on review of personnel files and staff interviews, the hospice failed to assure that an RN provide annual, on-site supervision for 4 of 6 aides who are providing care to hospice clients. The findings include: Per review of personnel records of 6 staff, hired at different times, the agency has not provided annual on-site supervision for 2 aides, within 12 months of their previous evaluation and 2 other staff have evaluations due within this month. Per interview on 04/09/2013 at 3:00 P.M. The Human Resource administrative staff stated there is currently no plan to provide for the upcoming evaluations, due on staff's anniversary hire dates during the month of April 2013. Staff #	L 632	A supervisory visit for all aides overdue for supervisory visits will be completed within their current hospice patient assignments. A calendar system of quarterly hospice aide supervision will be developed that completes annual hospice aide supervision within the quarter of their annual performance evaluation.	5/31/13 12/31/13

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L 632	Continued From page 6 2 was due for an annual on-site evaluation on 01/03/2013; Staff # 3 was due for an on-site evaluation on 02/04/2013; Staff # 1 and # 5 are due on 04/18/2013 and 04/23/2013, respectively. The Human Resource administrative staff also confirm at that time that annual reviews of aides, including competency reviews are not done on a regular basis at this time but that they are "in the process of trying to track this better".	L 632		
L 646	418.78(d) COST SAVING The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following: (1) The identification of each position that is occupied by a volunteer. (2) The work time spent by volunteers occupying those positions. (3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section. This STANDARD is not met as evidenced by: Based on interview and record review there is no documentation of cost saving achieved through the use of volunteers. Findings include: 1. Per interview on 04/09/13 at 8:45 A.M. the Volunteer coordinator stated that there are currently 20 volunteers and that they keep track of the time they spend with patients and then send a form to the office. However, per review of the forms for the past year not all times/dates are found for services provided. The Volunteer Coordinator stated " I'll start to enter that now that we know we have to do this" In addition, per	L 646	The volunteer coordinator will be trained in documentation of volunteer hours and cost savings within the EMR. A new process will be developed for tracking cost savings.	5/31/13

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L 646	Continued From page 7 request for the estimated cost savings on 04/09/13 the Hospice Director stated that "the billing department doesn't have that". S/he confirmed there is no documentation showing the cost savings achieved through the use of volunteers.	L 646		
L 647	also see L-647 418.78(e) LEVEL OF ACTIVITY Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked. This STANDARD is not met as evidenced by: Based on record review and interviews there is no evidence that the Hospice volunteers provided a minimum of 5% of administrative and/or direct patient care services. Finding include: 1. Per interview on 04/09/13 at 8:45 A.M. the Volunteer coordinator stated that there are currently 20 volunteers and that the volunteers enter the time spent with patients on a form and then they send it to the office. However, per review of the forms for the past year not all times/dates are found for services provided. The Volunteer Coordinator stated that s/he works part time and is implementing a new way to track hours and stated "I'll will start to enter that now that we know how to do this ". S/he confirmed there is no evidence the Hospice volunteers	L 647	An Agency process will be developed to determine day to day and/or direct patient care service costs to ensure that volunteer care equals a minimum of 5% of those costs.	6/30/13

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L 647	Continued From page 8 provided a minimum of 5% of administrative and/or direct patient care services.	L 647		
L 674	<p>also see L-646</p> <p>418.104(a)(3) CONTENT</p> <p>[Each patient's record must include the following:] (3) Responses to medications, symptom management, treatments, and services.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews the Hospice failed to have in the electronic medical record (EMR) clear documentation of services provided. Findings include:</p> <p>1. Per review of the EMR for 11 Hospice patients there was no documentation regarding volunteer clergy/spiritual and/or bereavement services. Per interview on 04/08/13 at 11:00 A.M. the Bereavement/MSW coordinator stated "since September [2012] when the person, who was the one sending out bereavement letters left, things fell through the cracks and we were not sure how to get the information into our [EMR] system". S/he stated that they are now, since January 2013, keeping track of the bereavement services via a spread sheet on a personal computer. S/he confirmed the patient's EMR does not contain bereavement services received and/or offered. In addition, clergy/spiritual information is not found in the EMR for patients requesting this service. Per interview on 04/09/13 at 9:18 A.M. the Chaplin stated "when I see patients I will fill out a spiritual care contact form and then they get scanned into the EMR". Per review of 2 charts in which the patients asked for spiritual support</p>	L 674	<p>Agency will train all professional staff including volunteer coordinator and chaplain on proper documentation of the hospice patient's and family's experience and goal achievement, including patient responses to medications, symptom management, and services offered, used and goal attainment using a holistic and comprehensive physical, psycho-social, and spiritual domain assessment approach.</p>	6/30/13

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L 674	Continued From page 9 there were no scanned documents showing services were provided. The Chaplin confirmed that the EMR did not have scanned information of the services provided to the 2 patients and stated "not sure what happened to them". The Hospice Director stated that there had been some staff changes and confirmed that "the EMR lacks consistency, doesn't flow, and we know we have to get the information such as volunteer/bereavement and chaplin services in the records".	L 674		