

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

August 13, 2012

Renee Kilroy, Administrator  
Caledonia Home Health Care  
161 Sherman Drive  
Saint Johnsbury, VT 05819-1146

Provider ID #:477010

Dear Ms. Kilroy:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **July 11, 2012**.

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

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:ne

Enclosure - FEDERAL



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

RECEIVED  
Division of LICENSING AND PROTECTION  
AUG 3 12  
PRINTED: 07/20/2012  
FORM APPROVED  
OMB NO. 0938-0391

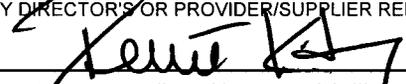
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____  Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>07/11/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CALEDONIA HOME HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>161 SHERMAN DRIVE SAINT JOHNSBURY, VT 05819</b>
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G 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced on site recertification survey was conducted on 07/09/12 - 07/11/12 by the Division of Licensing and Protection. The following are Federal findings.</p>	G 000		
G 158	<p><b>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</b></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 plan of care for the number of skilled nursing visits for 1 of 12 patients (Patient # 4) was not followed Findings include:</p> <p>Per record review on 7/9/12 for Resident # 4, the physician ordered daily skilled nursing visits(on 11/29/11) for wound care assessment and daily dressing changes. The orders became part of a the comprehensive plan of care developed for Patient # 4. Per record review of the nursing visits between the dates 11/29/11 (admission date) and 12/19/11 (the date the nurse wrote an order to decrease skilled nursing visits to 2 times per week) there were 9 daily nursing visits missed (12/3, 12/4, 12/10, 12/11, 12/12, 12/14, 12/15, 12/17 &amp; 12/18/11) with no explanation by the nurse as to why visits were missed or communication to the physician that visits were not made.</p> <p>On 7/9/12 at 3:40 P.M. the home care manager confirmed that the plan of care had not been followed because the skilled nursing visits had not been made daily as ordered and confirmed</p>	G 158	See attachment	

*P.O.C accepted  
S. Emmons / Franush / W  
8/9/12*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>COO</b>	(X6) DATE <b>8/2/12</b>
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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.

*pmc*

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G 158	Continued From page 1 the physician had not been notified.	G 158		
G 170	See 0170 484.30 SKILLED NURSING SERVICES  The HHA furnishes skilled nursing services in accordance with the plan of care.  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. Findings include:  Per record review on 7/9/12 for Resident # 4, the physician ordered daily skilled nursing visits(on 11/29/11) for wound care assessment and daily dressing changes. The orders became part of a the comprehensive plan of care developed for Patient # 4. Per record review of the nursing visits between the dates 11/29/11 (admission date) and 12/19/11 (the date the nurse wrote an order to decrease skilled nursing visits to 2 times per week) there were 9 daily nursing visits missed (12/3, 12/4, 12/10, 12/11, 12/12, 12/14, 12/15, 12/17 & 12/18/11) with no explanation by the nurse as to why visits were missed or communication to the physician that visits were not made. On 7/9/12 at 3:40 P.M. the home care manager confirmed that the plan of care had not been followed because the skilled nursing visits had not been made daily as ordered and also confirmed the physician had not been notified.	G 170	See attachment	
G 173	See 0158 484.30(a) DUTIES OF THE REGISTERED	G 173	See attachment	

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G 173	Continued From page 2 NURSE  The registered nurse initiates the plan of care and necessary revisions.  This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to revise the careplan for 1 of 12 patients (Patient # 4) when there was a change in the plan of care. Findings include:  Per record review on 7/9/12 the registered nurse failed to revise the care plan for Resident # 4 who had physician orders for daily skilled nursing visits for wound assessment/dressing changes. Per nursing documentation, between the dates 11/29/11 and 12/19/11 the patient failed to have a skilled nursing visit 9 times during this period. (Dates 12/3, 12/4, 12/10, 12/11, 12/12, 12/14, 12/15 12/17 & 12/18/11) Per interview with the home care manager she confirmed on 7/9/12 at 3:40 P.M. that the 9 nursing visits had not been made during the above time period and the plan of care was not revised to show the visits were not made because the spouse had been taught (by the nurse) to do the dressing changes and agreed to change the dressings those days the nurse did not visit.	G 173			
G 212	484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI  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 attachment		

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G 212	Continued From page 3  This STANDARD is not met as evidenced by: Based on interview and record review, the Home Health Agency failed to ensure the ongoing competency of a home health aide involved in an accident with a client while using transfer equipment. (Client #6) Findings include:  Per record review, Client #6 with a diagnosis of lower extremity motor and sensory loss and dependent on home health agency staff for transfers using a Hoyer lifting/transfer device, sustained a back sprain injury on 4/28/12 after a fall from the transfer device being operated by a home health aide. Per review on 7/11/12 the "Incident/Variance Report" stated while the home health aide was transferring the client a knob was accidentally bumped causing Client #6 to be accidentally lowered to the ground. The only follow up regarding the accident was an undated note on the "Incident/Variance Report" stating a verbal review of the Hoyer lift procedure with the home health aide was conducted by the home care manager. Per interview on 7/11/12 at 1:15 PM, the home care manager confirmed that after the accident, agency staff failed to provide in-home direct supervision to reassess the competency of the home health aide in the use of the Hoyer transfer device for which s/he had been previously trained to use and to ensure the ongoing safety of the client during transfers.	G 212			
G 214	484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI  The HHA must complete a performance review of each home health aide no less frequently than every 12 months.	G 214	See attachment		

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G 214	Continued From page 4  This STANDARD is not met as evidenced by: Based on interview and record review, the Home Health Agency failed to ensure that 4 of 5 home health aides had a performance evaluation completed every 12 months. Findings include:  Per review on 7/11/12 of home health aide personnel files, performance evaluations had not been conducted for 4 of the 5 home health aides presently providing care and services to clients. It was greater than 2 years since one home health aide had a performance evaluation from his/her supervisor. Per interview at 1:30 PM on 7/11/12, the Human Resource Manager confirmed performance evaluations had not been completed as per requirement.	G 214			
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 interviews the agency failed to have current and /or accurate clinical records for 2 of 12 applicable patients in the sample. (Patients # 3, & # 5 ] Findings include:	G 236	See attachment		

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G 236	Continued From page 5  1. Per record review on 07/09/12 client #3's electronic chart did not contain a discharge summary of all services received. The client received received occupational therapy (OT) , nursing services and home health aide (HCA) care during the recertification period of 03/11/12 - 05/09/12. An O-T discharge summary was noted on 04/04/12 contained a summary of the treatment and goals met. The client was discharged on 05/09/12 with a nursing note stating "client is no longer in need of HCA services at this time-d/c ". There is no discharge summary as to whether the client met the nursing goals nor the disposition of the client at the time of discharge. Per interview on 07/09/12 at 3:35 PM the Home Care Manager stated that the expectation would be that nursing would write a discharge summary of services and outcomes of the goal and confirmed that there was no discharge summary from nursing.  2. Per record review on 07/09/12, Client #5 had been transferred to the hospital after a fall at home on 3/9/12. An Oasis "transfer status" was completed on 03/10/12 in the electronic medical record. (EMR) An entry was noted in the EMR for 04/30/12 however there was no written documentation indicating Client #3 was discharged from the home health agency. Per interview on 07/11/12 at 12:05 PM the Home Care Manager/RN confirmed that although Agency staff had been informed Client #5 was admitted to a long term care facility and would not return to home care services, there was no documentation in the EMR to reflect the disposition of the client and/or a discharge summary to reflect why the client was discharged	G 236			

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G 236	Continued From page 6 off service.	G 236		
G 239	<p>484.48(b) PROTECTION OF RECORDS</p> <p>Clinical record information is safeguarded against loss or unauthorized use.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the home health agency failed to ensure the confidentiality and safeguard of clinical records. Findings include:</p> <p>1. Per observation on 07/09/12 -07/11/12 - stacks and piles of loose papers on open book shelves and a small end table, were in the office next to the front door. During the afternoon on 07/09/12 at approximately 1:25 PM the door to the office was open and no staff were in the general area. Per interview on 07/11/12 at 8:15 AM the medical secretary and and the clinical manager stated "we are behind on the scanning but we try to get it done when we can" Upon further interview and observation some of the client's information is well over a year old dating back to April/ May of 2011 and is still not scanned into the current medical record . During this interview both the medical secretary and clinical manager stated "we lock the door at night" but confirmed that the records are not safeguarded.</p>	G 239	See attachment	

Attachments

DLP Survey – Medicare/Medicaid Programs

Prefix Tag	COP Number	Plan of Correction	Completion Date
G 158	484.18	<p>Agency will hold a Professional Staff Inservice/ Education training on 8/22/12 that will cover the following agenda item:</p> <ul style="list-style-type: none"> <li>• Regulations regarding adherence to and revision of physician ordered plans of care – visit frequency, clinical orders, medications</li> </ul> <p>This will be monitored during the quarterly Peer Review process and during routine case conferences with the Team Leader.</p>	8/22/12
G 170	484.30	<p>Agency will hold a Professional Staff Inservice/ Education training on 8/22/12 that will cover the following agenda item:</p> <ul style="list-style-type: none"> <li>• Regulations regarding adherence to and revision of physician ordered plans of care – visit frequency, clinical orders, medications</li> </ul> <p>This will be monitored during the quarterly Peer Review process and during routine case conferences with the Team Leader.</p>	8/22/12
G 173	484.30(a)	<p>Agency will hold a Professional Staff Inservice/ Education training on 8/22/12 that will cover the following agenda item:</p> <ul style="list-style-type: none"> <li>• Regulations regarding adherence to and revision of physician ordered plans of care – visit frequency, clinical orders, medications</li> </ul> <p>This will be monitored during the quarterly Peer Review process and during routine case conferences with the Team Leader.</p>	8/22/12
G212	484.36(b)(1)	<p>Home Health Aides are evaluated annually for competency at the time of their Annual Performance Evaluation. The Home Health Aide in question had documentation in his personnel record to reflect current satisfactory competency. On this particular occasion, the client accidentally hit the knob to lower the lift. Clinical Manager responded by promptly re-educating Home Health Aide on hooyer lift transfers, in the office setting. It was felt that this Home Health Aide's competency with hooyer lift transfers was not in question, as his annual competency was current and due to the number of times he had successfully</p>	8/31/12

		<p>performed this transfer in the last year (217 times). This Home Health Aide will have a competency performed at his Annual Performance Evaluation.</p> <p>The competency of staff involved in any future incidents resulting in client injury will be reassessed in the home by the appropriate professional clinician in a timely manner.</p>	
G 214	484.36(b)(2)(ii)	<p>The Human Resource Department has developed a process to assure Annual Performance Evaluations and competencies are completed annually and timely.</p> <ul style="list-style-type: none"> <li>• Human Resources will distribute electronic forms to supervisor for completion</li> <li>• Supervisor will complete form and submit evaluation to their supervisor for signature</li> <li>• Evaluation is reviewed with employee and signed</li> <li>• Evaluation is submitted to Human Resources for inclusion in the employee's personnel record</li> </ul> <p>Each evaluation will have a due date. Human Resources will give a one week notice to the supervisor if the evaluation is not completed at 15 days following the due date. If evaluation is still incomplete, the supervisor may become subject to disciplinary action.</p>	8/1/12
G236	484.48	<p>Agency will hold a Professional Staff Inservice/ Education training on 8/22/12 that will cover the following agenda item:</p> <ul style="list-style-type: none"> <li>• Regulations regarding contents of the clinical record, including, but not limited to discharge summaries.</li> </ul> <p>This will be monitored during the quarterly Peer Review process and during routine case conferences with the Team Leader.</p>	8/22/12
G239	484.48(b)	<p>The agency will ensure the confidentiality and safeguarding of clinical records. Clinical records will be filed in individually identified patient files and stored in locked metal four-drawer filing cabinets. The secured filing cabinets will be housed in an interior building room accessible only via a locked door. A master key to all files will be stored with the facilities manager. Patient information arriving daily will be filed and stored appropriately as outlined above or scanned into an electronic filing system.</p>	8/31/12