

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

April 2, 2015

Treny Burgess, Administrator
Caledonia Home Health Care
161 Sherman Drive
Saint Johnsbury, VT 05819-1146

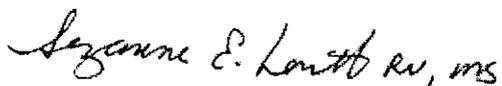
Provider ID #:477010

Dear Ms. Burgess:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 18, 2015**.

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

Sincerely,



Suzanne Leavitt, RN, MSN
State Survey Agency Director
Assistant Division Director

Enclosure

PRINTED: 03/12/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VT477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/18/2015
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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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(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) COMPLETE DATE
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H 001	Initial Comments An unannounced onsite investigation into two self-reported incidents was conducted by the Division of Licensing and Protection on 2/10/15, and concluded on 2/18/15. The following regulatory deficiencies were identified.	H 001	<i>See attached</i>	
H 517 SS=D	5.7(a) Requirements for Operation V. Requirements for Operation 5.7 A home health agency shall notify the Department of all critical incidents among its current patient population within specified time frames below. Verbal reports shall be followed by a written report that summarizes the occurrence. (a) A home health agency shall report any suspicion of abuse, neglect or exploitation as defined in 33 V. S. A. §6902 to the Division of Licensing and Protection's Adult Protective Services unit within 48 hours. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the agency failed to file a report of staff neglect of a resident within the required timeframe for 1 of 2 patients sampled (Patient #1). Findings include: Per record review on 2/10/15, a caregiver filed a complaint on 1/3/15 with the agency alleging that a Personal Care Attendant (PCA) had left a totally dependent person (Patient #1) alone in their home while the caregiver was out running errands. The agency immediately suspended the PCA from visits, and began an internal investigation. Per interview on 2/10/15 at 2:25 PM, the Clinical Manager stated that the PCA had	H 517		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Larry F. Boyers

Director

3/25/15

PRINTED: 03/12/2015
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CALEDONIA HOME HEALTH CARE

161 SHERMAN DRIVE
SAINT JOHNSBURY, VT 05819

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H 517	Continued From page 1 been reported to the Board of Nursing for leaving the patient alone, however there was not a report filed for potential neglect with Adult Protective Services until 1/12/15, which was not within 48 hours of the agency being aware of the allegation.	H 517		
H1303 SS=D	<p>13.3 Unlicensed Caregiver Services</p> <p>XIII. Unlicensed Caregiver Services</p> <p>13.3 A home health agency shall train and determine the competency of unlicensed caregivers employed by the agency to perform specific tasks for specific patients and shall ensure that the caregiver is appropriately supervised.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and caregiver interviews, the agency failed to ensure that a Personal Care Attendant (PCA) recieved proper orientation and supervision in the care of 1 of 2 patients sampled (Patient #1). Findings include:</p> <p>Per record review on 2/10/15, Patient #1 had a start of care date of 11/13/12, due to being in a persistant vegetative state, and requiring full caregiver assistance for all Activities of Dally Living. The patient recieved nutrition through a G-tube, was on seizure precautions, and recieved passive range of motion to all extremities daily. Per review of the PCA care plan for this patient, there were personal care tasks that include bed bath, dressing the patient, perineal care, shaving, observing seizure precautions, feeding with G-tube (and to be sure bag does not run out, alternating between Jevity and Pedialyte),</p>	H1303		

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H1303	<p>Continued From page 2</p> <p>repositioning in bed with special instructions to be sure rail is halfway up on left side of bed to prevent patient from getting stuck in the gap if a seizure occurs, and some housekeeping tasks such as laundry and sweeping the floor. Per a self-reported incident by the agency, a Personal Care Attendant who is licensed as a Nursing Assistant was caring for the patient in the home on 1/3/15. The family caregiver of the patient was out of the home running errands while the PCA was providing care. When the caregiver returned to the home, Patient #1 was found alone in the home, uncovered, and the PCA had left. When the agency recieved a complaint from the caregiver on 1/3/15, they immediately started an internal investigation, and did not have the PCA return to Patient #1's home the following day. Per the internal investigation summary, the PCA stated that when care was completed for this patient, the caregiver would dismiss them when care was complete, as the caregiver was there. On the day of 1/3/15, the PCA left while the caregiver was still out of the house, leaving Patient #1 alone, despite having no ability to respond to any type of emergency that might have occurred, including the ability to telephone for assistance. Per review of the documentation, there was no evidencé of an orientation to the care of Patient #1 by a nurse. Per interview on 2/10/15 at 2:25 PM. the Clinical Manager most familiar with this case confirmed that the PCA had been oriented by another PCA who was experienced in the care of Patient #1, however had not been oriented by a nurse to delegate the care tasks to the PCA. Due to the complex nature of the case, including G-tube feedings, preventative measures for contractions, Seizure precautions, and specialized instruction for positioning, the Clinical Manager confirmed that a nurse should have been the one orienting the</p>	H1303		

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H1303	Continued From page 3 new PCA to the patient's care, to ensure that they were able to correctly provide care per the instructions in the PCA care plan.	H1303		

Attachments

DLP Survey – State Designation and Operations – Plan of Correction 3/25/15

Prefix Tag	Designation Rule Number	Plan of Correction	Completion Date
H517 SS=D	5.7(a)	Review/revise reporting policy and process to ensure alignment with state and federal rules and regulations. Review/revise orientation of new staff to ensure that the policy and process is addressed. Educate all staff regarding the process, and re-educate yearly to ensure that the process continues.	Treny Burgess, Director 5/8/15
H1303 SS=D	13.3	Review and revise the policy/procedure concerning orientation of PCA's to patients with complex plans of care. Education of PCA's and clinicians regarding the revised process. Audits will be done quarterly by the PCA supervisor to ensure that all PCA's that are caring for patients with complex plans of care have been oriented by a nurse.	Allison Wright-Roberts, RN 5/8/15

*POC complete
4.1.15
K. Dupas / SGA*