

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

October 13, 2014

Ms. Treny Burgess,
Caledonia Home Health Care
161 Sherman Drive
Saint Johnsbury, VT 05819

Dear Ms. Burgess:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 8, 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,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
State Survey Agency Director

Enclosure

FK:kc

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

PRINTED: 09/19/2014
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
Division of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	OCT -- 3 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 09/08/2014
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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) COMPLETION DATE
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L 000	INITIAL COMMENTS	L 000		
L 537	<p>418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES</p> <p>The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that all the interdisciplinary team members gave input to develop the plan of care for one sampled patient (Patient #1). Findings include:</p> <p>Per record review on 8/27/14, Patient #1 was admitted to Hospice care on 2/4/14, the day s/he signed the election of the Hospice benefit. The initial nursing assessment was completed on this day also. Per review of the Interdisciplinary Team (IDT) notes, there was no meeting until 2/11/14, when the case of Patient #1 was discussed by the team. Although the admitting nurse and MD were involved in developing the plan of care, it was completed before the 2/11/14 IDT meeting. Per interview with the Hospice Clinical Manager, the team does not meet in between their weekly meetings, and the team would only be consulted if there was an urgent matter between meetings. On 8/27/14 at 3:25 PM, the Hospice Manager confirmed that the plan of care for Patient #1 was developed without documented evidence of the</p>	L 537	<p>Agency will review/update policy & procedure regarding IDG, care planning and coordination of services to ensure compliance with COP 418.56.</p> <p>Agency will develop audit tool which will include verification of IDG, care planning and coordination of services at start of care and appropriate intervals in compliance with CDP 418.56 and agency policy & procedure.</p> <p>Agency will hold staff in-service/training that will cover the following agenda items:</p> <ul style="list-style-type: none"> Regulations regarding IDG, care planning and coordination of services per COP 418.56 Agency policy/procedure regarding IDG, care planning and coordination of services per COP 418.56 to ensure compliance <p>This will be monitored using the developed audit tool following each start of care until 100% compliant. Audit tool will then be used randomly at a frequency determined appropriate at that time.</p>	11/14/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Lenny A. Bungers

TITLE
Director

(X6) DATE
10/13/14 9/29/14

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.

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L 537 L 697	<p>Continued From page 1 entire IDT team having input into the plan of care.</p> <p>418.106(e)(2)(i)(C) LABEL DISPOSE STORAGE DRUGS</p> <p>[At the time when controlled drugs are first ordered the hospice must:] (C) Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the Hospice Agency failed to ensure that the record of controlled drugs delivered to the home and disposal of controlled drugs were documented in the medical record for one patient sampled (Patient #1). Findings include:</p> <p>Per record review on 8/27/14, Patient #1 was admitted to Hospice care on 2/4/14. Per review of the Nurse Visit notes, there was no mention of delivery of a comfort kit with an inventory of the contents to the home and education given to the caregiver on the use of the medications. There were allegations of medication diversion, and the MD added orders On 3/6/14 to count controlled drugs at each visit. Although nursing was documenting the amount of certain drugs in the home, the contents of the comfort kit were not measured/counted and documented at each visit. Nurse Visit note on 3/8/14 stated that 46 Vicodin/Decloffenac disposed of, 54 Dilaudid tabs in house, 4 Fentanyl patches, and a bottle of liquid Morphine. Also stated that there was no Ativan, Haldol, or Prochlorperazine in the home. According to the Hospice manager, the comfort kit would have contained all these items. There</p>	L 537 L 697	<p>Agency will review/update policy & procedure regarding management of controlled drugs to ensure compliance with COP 418.106(e)(2)(i)(c).</p> <p>Agency will develop audit tool which will include verification of management of controlled drugs and documentation of such in compliance with COP 418.106(e)(2)(i)(c) and agency policy & procedure.</p> <p>Agency will develop document to be signed by patient/family upon receipt of Comfort Kit. This document will include agency policy/procedure for managing controlled drugs and acknowledgement of acceptance of comfort kit and its contents.</p> <p>Agency will hold staff in-service/training that will cover the following agenda items:</p> <ul style="list-style-type: none"> - Regulations regarding management of controlled drugs per COP 418.106(e)(2)(i)(c) - Agency policy & procedure regarding management of controlled drugs per COP 418.106(e)(2)(i)(c) to ensure compliance <p>This will be monitored using the developed audit tool.</p>	11/14/2014

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L 697	Continued From page 2 was no documentation of the receipt or disposal of these medications in the record. The notes from the nurse's visit on 3/8/14 stated that there was 54 tablets of Dilaudid 2 mg. in the home. Per the next nursing visit on 3/11/14, there was no mention of the Dilaudid tablets and how many if any were left. On 3/14/14, the nurse's visit note did not mention any reconciliation of the narcotic medications in the home. On 3/22/14, some of the medication was accounted for, the Fentanyl patches and the Dilaudid, however there was no mention of the liquid Morphine and whether any remained. Per interview on 8/27/14 at 3:30 PM, the Hospice Clinical Manager confirmed that there was no documentation in the clinical record of the delivery of the comfort kit and its contents, evidence of patient education regarding the use of those drugs, and that staff were inconsistent in accurately accounting for the narcotic medications at each visit after the allegation of medication diversion was identified.	L 697	<p><i>addendum</i></p> <p><i>Per T.C 10⁰⁵am</i></p> <p><i>10/13/14</i></p> <p><i>The Assistant Director of Hospice and the Executive Director will be responsible for monitoring compliance</i></p> <p><i>K. Campos / F. Keen</i></p> <p><i>10/13/14</i></p>	
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