

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

January 29, 2016

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

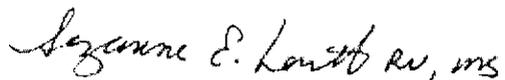
Provider ID #:471502

Dear Ms. Burgess:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 29, 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



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

PRINTED: 12/31/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>471502 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C.<br>12/29/2015 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>CALEDONIA HOME HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>161 SHERMAN DRIVE<br>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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|       |   |       |              |  |
|-------|---|-------|--------------|--|
| L 000 | INITIAL COMMENTS  | L 000 |              |  |
| L 537 | <p>An unannounced onsite survey was conducted on 12/29/15 following an entity report. The following regulatory violations were cited.</p> <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:<br/>Based on record review and staff interview, the agency failed to ensure that all the team members gave input to develop the plan of care for three of three sampled clients (Clients #1, 2 and 3). Findings include:</p> <p>Per record review on 12/29/15 of the interdisciplinary team meeting minutes from April 2015 through present (December 28, 2015), shows evidence that all team members whether the physician, social worker and/or clergy were not consistently present to give full participation for the plan of care. Client # 1 was admitted 05/27/15, Client #2 was admitted 06/04/14 and Client #3 was admitted 09/04/15. As noted one or more of the main core members were missing in order to give input or revisions for the plan of care and no information was found for the month of September 2015. No documentation that the physician was present in April 11, 14, 28 June 2, 23, 30, July 26, Aug 18, October 6, &amp; 27, November 10 &amp; 24 and December 1 &amp; 8. There was no documentation that the social worker participated on October 20, November 13 and</p> | L 537 | SEE ATTACHED |  |

|   |                          |                              |
|---|--------------------------|------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Amy Burgess</i> | TITLE<br><i>Director</i> | (X6) DATE<br><i>01/14/16</i> |
|---|--------------------------|------------------------------|

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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|--|---|--|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>CALEDONIA HOME HEALTH CARE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>181 SHERMAN DRIVE<br>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 |   |
| L 537  | Continued From page 1<br>December 1. No Chaplin/clergy on June 30 and October 3 was noted.<br>The Director of Hospice at 4:30 P.M. confirmed the above findings.  | L 537  |   |                      |   |
| L 594  | 418.64(c) MEDICAL SOCIAL SERVICES<br><br>Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.<br><br>This STANDARD is not met as evidenced by:<br>Based on the patient's psychosocial assessment and the patient's and family's needs, these services was not provided in a timely manner for 1 of 3 cilents in the sample. (Client #1) Findings include:<br><br>Per record review on 12/29/15 Cilent #1 was admitted to services on 05/27/15 and did not receive psychosocial services in a timely manner. The initial assessment notes dapression and anxiety, general concerns regarding emotional balance and psychosocial needs, with help due to strong emotion and notes 'immediata psychosocial support required'. The assessment also shows "needs to improve/handle strong emotions, address anxiety". The social worker {MSW} made a visit approximately 10 weeks later on 08/11/15 . There is no documentation that the family had refused social services prior to the first visit. The Director of Hospice on 12/29/15 at 1:48 P.M. stated that the expectation would be that the MSW would make a visit soon after the assessment and acknowledged that there is no | L 594  | SEE ATTACHED  |                      |   |

*Henry L Burgess* Director

01/24/16

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| NAME OF PROVIDER OR SUPPLIER<br><br>CALEDONIA HOME HEALTH CARE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>181 SHERMAN DRIVE<br>SAINT JOHNSBURY, VT 05819                         |                      |   |
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| L 594  | Continued From page 2<br>documentation that the client had refused services. The Director of Hospice confirmed that the psychosocial needs were not provided in a timely manner for Client #1. | L 594  |   |                      |   |

*Treny H. Burgess* Director

01/14/16

ATTACHMENT

Caledonia Home Health & Hospice Survey 12/29/15

Plan of Correction

| Prefix Tag | COP Number | Plan of Correction  | Person responsible/<br>Completion Date                                       |
|------------|------------|---|--|
| L 537      | 418.57(a)  | <p>Agency has identified more than one area for improvement regarding COP 418.57(a.)</p> <ul style="list-style-type: none"> <li>➤ Improve competency of Core IDG members regarding the requirements</li> <li>➤ Optimize EMR functionality for complete documentation</li> <li>➤ Improve quality control of requirements and documentation</li> </ul> <p>❖ Agency has re-assigned clinical oversight of Hospice program to the Assistant Director of Home Care</p> <p>❖ Hospice Management Team will:</p> <ul style="list-style-type: none"> <li>○ Review/revise policy, "Interdisciplinary Group Membership and Responsibilities"</li> <li>○ Complete online learning module, "Relias- The Interdisciplinary Group, the Care Planning Process, and Coordination of Services, Parts 1 &amp; 2" <ul style="list-style-type: none"> <li>▪ "This two-part presentation from Weatherbee's Hospice Regulatory Boot Camp in Denver, CO, 2008, focuses on challenges and implementation strategies for the new IDG, Care Planning and Coordination of Services CoP. V105." Objectives: Name the five standards that comprise this Condition of Participation. State time frames required for plan of care review. Describe connection between plan of care and patient assessment. Describe hospice's responsibility for coordinating with other health care providers to fill any gaps in the patient's overall comprehensive plan of care. Describe an effective IDG meeting format. List the functions of the IDG meeting facilitator, timekeeper, and scribe."</li> </ul> </li> <li>○ Be educated on use of EMR to its maximum potential for documentation of IDG meeting</li> <li>○ Design a new process for performing and documenting interdisciplinary care planning and IDG meetings, using the above mentioned educational references</li> </ul> <p>❖ Agency will hold Hospice staff in-service/training which will include:</p> <ul style="list-style-type: none"> <li>○ Completion of online learning module, Relias- The Interdisciplinary Group, the Care Planning Process, and Coordination of Services, Part 1</li> </ul> | <p>03/01/16</p> <p>Michelle Downing-<br/>Assistant Director of Home Care</p> |

*James R. Bugers Director*

*01/14/16*

|      |           |  |  |
|------|-----------|--|--|
|      |           | <ul style="list-style-type: none"> <li>▪ "This two-part presentation from Weatherbee's Hospice Regulatory Boot Camp in Denver, CO, 2008, focuses on challenges and implementation strategies for the new IDG, Care Planning and Coordination of Services CoP. V105." Objectives: Name the five standards that comprise this Condition of Participation. State time frames required for plan of care review. Describe connection between plan of care and patient assessment. Describe hospice's responsibility for coordinating with other health care providers to fill any gaps in the patient's overall comprehensive plan of care." <ul style="list-style-type: none"> <li>○ Education on policy, "Interdisciplinary Group Membership and Responsibilities"</li> <li>○ Instruction on use of EMR to its maximum potential for documentation of IDG meeting</li> <li>○ Instruction on new process for performing and documenting interdisciplinary care planning and IDG meetings</li> </ul> </li> <li>❖ A staff member will be designated to audit every IDT meeting in EMR to assure physical, medical, psychosocial, emotional, and spiritual needs are addressed and documented by all core members at least every 15 days until 100% compliant. Audit tool will then be used randomly at a frequency determined appropriate at that time.</li> </ul>   |  |
| L594 | 418.64(c) | <p>Agency has identified more than one area for improvement regarding CDP 418.64(c)</p> <ul style="list-style-type: none"> <li>➤ Improve social work staff competency regarding COP 418.64(c) and associated policies</li> <li>➤ Improve social work staff competency regarding documentation requirements</li> <li>➤ Provide increased supervision/support to social work staff</li> </ul> <ul style="list-style-type: none"> <li>❖ Agency has re-assigned clinical supervision of social work staff to the Assistant Director of Home Care</li> <li>❖ Supervisor will meet with social work staff as often as daily until deemed unnecessary by Administrator. These meetings will involve, but are not limited to: <ul style="list-style-type: none"> <li>○ Education on COP 418.64(c) and associated policies</li> <li>○ Mentoring regarding scheduling and expectations for communication with clients and families</li> </ul> </li> <li>❖ Social work staff will complete online learning module, Rellas- "Legal aspects of documentation to meet regulatory guidelines"</li> <li>❖ Designated staff member will audit every Hospice Start of Care to assure psychosocial needs are addressed and documented by social work at least every 15 days until 100% compliant and deemed no longer necessary by Administrator</li> </ul> <p><i>Poc ACCEPTED FOR L537 &amp; L594</i><br/> <i>Susan J. Emmers RN 1/27/16</i></p> | <p>03/01/16</p> <p>Michelle Downing- Assistant Director of Home Care</p> |

*Laney R Burgess Director*

*01/14/16*