

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

December 23, 2014

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

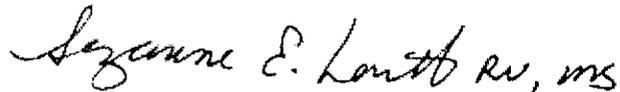
Provider ID #:477010

Dear Ms. Burgess:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 19, 2014**.

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

Sincerely,



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

Enclosure



Attachments

DLP Federal Survey

Prefix Tag	COP Number	Plan of Correction	Person Responsible/Completion Date
G 103	484.10(a)(2)	<p>Review and update the policy/procedure regarding written notification of Patient Rights in accordance with COP 484.10(a)(2) for patients who are case managed by other agencies.</p> <p>Educate staff regarding COP 484.10(a)(2) and our revised policy/procedure.</p> <p>Audits will be done quarterly and on-going through peer review process to ensure correction of deficiency.</p>	<p>Community Based Care Manager; Quality and Performance Improvement Manager</p> <p>01/30/2015</p>
G144	484.14(g)	<p>Review/revise procedure regarding how interdisciplinary referrals are processed, both upon intake and during a patient's certification period.</p> <p>Team Leaders will utilize existing software reports to ensure ongoing compliance of supervision of Home Health aides.</p> <p>Educate staff regarding:</p> <ul style="list-style-type: none"> • COP 484.14(g); • Revised interdisciplinary referral procedure, both on intake and during certification period; • Expectation of interdisciplinary communication/transfer of supervision of LNA's upon d/c of responsible case manager. <p>Audits will be done quarterly and on-going through peer review process to ensure correction of deficiency.</p>	<p>Quality and Performance Improvement Manager (Intake and Referral); Nursing/PT Supervisors; Community Based Care Manager</p> <p>01/30/2015</p>
G159	484.18(a)	<p>Review/revise procedure regarding how interdisciplinary referrals are processed, both upon intake and during a patient's certification period.</p> <p>Improve communication regarding patient's plan</p>	<p>Quality and Performance Improvement Manager; Community Based Care Manager</p>

*Documents re/son
12.22.14*

*Documents re/son
12.22.14*

Attachments

DLP Federal Survey

		<p>of care for CFC patients case managed by other agencies:</p> <ul style="list-style-type: none"> Institute policy and procedure for development and communication of PCA/Homemaker care plans, including necessary documentation; This will include referrals to necessary disciplines to assess and instruct regarding safety issues; Educate staff and other agencies regarding COP 484.18(a) and policy and procedure through in-services and memos; Review clinical records of current clients to ensure this requirement is met. <p>Audits will be done quarterly and on-going through peer review process to ensure correction of deficiency.</p>	<p>01/30/2015</p> <p>01/30/2015</p> <p>01/30/2015(on-going)</p>
G166	484.18(c)	<p>Review the process for ensuring timely signatures for the plan of care/verbal/interim orders:</p> <ul style="list-style-type: none"> Ensure the responsible supervisors are educated in the use of existing software reports regarding unsigned 485/POT and interim orders; Assistant Director of Home Care will monitor these reports weekly to ensure process is being followed. 	<p>Assistant Director of Home Care; Nursing/PT Supervisors</p> <p>01/30/2015 (on-going)</p>
G229	484.36(d)(2)	<p>Educate staff regarding 484.36(d)(2) and interdisciplinary communication/transfer of supervision of LNA's upon d/c of responsible case manager.</p> <p>Team Leaders to utilize existing software reports weekly to ensure ongoing compliance with supervision of Home Health aides.</p> <p>Audits will be done quarterly through peer review process to ensure correction of deficiency.</p>	<p>Assistance Director of Home Care; Nursing and PT Supervisors</p>

*Beaumont
12.22.14
KC/SL*

*Beaumont
12.22.14
KC/SL*

*Beaumont
12.22.14
KC/SL*

Attachments

DLP Federal Survey

G230	484.36(d)(3)	<p>Addition of full time RN Case Manager as of 01/05/2015 which will increase the number of staff available to perform supervision of PCA. Orient new RN Case Manager to PCA supervision requirements.</p> <p>Monthly utilization of existing software reports to monitor PCA supervisions.</p> <p>Audits will be done quarterly and on-going through peer review process to ensure correction of deficiency.</p>	<p>Community Based Care Manager</p> <p>01/30/2015</p>
G248	484.52(a)	<p>Develop process for systematically reviewing and revising agency policies and administrative practices to ensure that they accurately reflect current/best practice and promote patient care that is appropriate, adequate, effective and efficient.</p>	<p>Quality and Performance Improvement Manager; Operations Support Manager</p> <p>01/30/15</p>

*PC audit
12-22-14
KC/8*

*PC audit
12-22-14
KC/8*

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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
G 000	INITIAL COMMENTS	G 000		
G 103	<p>An unannounced onsite federal recertification survey was conducted by the Division of Licensing and Protection from 11/17 - 11/19/14. The following are regulatory findings.</p> <p>484.10(a)(2) NOTICE OF RIGHTS</p> <p>The HHA must maintain documentation showing that it has complied with the requirements of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interviews the HHA (Home Health Agency) failed to have, in 1 of 16 patients' records, documentation of the written notice of the Patient's Rights. (Patient #2) Findings include:</p> <p>1. During a home visit on 11/18/14 at 11:30 AM, information regarding the patients's rights which would include information such as the Home Health Hotline, complaint or grievance procedures, abuse prevention information, advanced directives information or other contact information was not found. No patient handbook or posting of Agency telephone numbers was found. Patient #2 was not able to remember if the information about patient's rights was given and/or discussed. Per record review on 11/18/14, which included the electronic medical record [EMR] and paper hard copies, no documentation that showed the patient was informed of the patient's rights was found. Per interview on 11/18/14 at 2:13 PM the Nurse Manager confirmed that there was no documentation showing the patient was informed of the Patient Rights.</p>	G 103		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Henry Burgess* TITLE *Director* (X6) DATE *12/16/14*

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.

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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
G 144	<p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the HHA failed to assure there was effective coordination of services between disciplines at the time of referral and consistent exchange and reporting of patient care needs during the provision of services for 4 of 16 applicable patients. (Patients #1, #3, #4, and #5) Findings include:</p> <p>1. Per review on 11/18/14 the referral for home health services for Patient # 5 included the request to have a Medical Social Worker (MSW) conduct an evaluation of potential social and emotional factors associated with Patient #5's present health condition and care needs. At the time of a joint home visit with agency staff on 11/18/14, the surveyor was informed by a family member presently providing continuous care to their parent (Patient #5), they would benefit from the assistance of a MSW. Although the HHA had received the referral on 10/16/14 requesting the services of a MSW, a visit was never made. Per interview on 11/18/14 at 2:10 PM, the Nursing Supervisor confirmed the request for MSW services at the time of referral did not get processed correctly and there was a failure in communication and coordination within the Agency regarding the intake of referrals. Per interview on 11/19/14 at 9:40 AM, the MSW also</p>	G 144		

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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	
G 144	<p>Continued From page 2</p> <p>confirmed s/he had not received notification for services to be provided to Patient #5.</p> <p>2. Based on record review and staff interview the agency staff failed to document the coordination of referral information and follow up case conferences with Patient #4. Per review on 11/17/14 of the referral information received on 10/30/14, presents that the physician requested nursing and medical social workers (MSW) services for this patient, who has a diagnosis of pancreatic cancer. Nursing made a home visit on 10/31/14, however there was no visit scheduled or ordered for the MSW visit. Per a visit note dated 11/08/14 the nurse wrote the patient's significant other was requesting help obtaining information for various community services. A verbal order was written for a MSW visit. The MSW made a home visit on 11/17/14, nearly three weeks after the original request. Per interview on 11/19/14 at 9:53 AM the MSW stated that the intake person would write a verbal order, to put it in the system, for the visit and then notify that staff person of the schedule for a visit. The MSW acknowledged that the initial intake request for the MSW visit was not done. The MSW further stated that after the 11/08/14 verbal order, s/he did contact the patient to set up the visit as well as talk to the patient but "didn't write it in the call log of my communication [with the patient]". The MSW confirmed there was not effective coordination of services between disciplines at the time of referral nor documentation of case conferences.</p> <p>3. Per record review on 11/18/14, Patient #3 was admitted to agency services on 5/8/14, for aftercare for a fractured hip. The orders for service included Skilled Nursing, Physical</p>	G 144			

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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	
G 144	Continued From page 3 Therapy, Occupational Therapy, and a Home health aide for assist with personal care. Per review of the supervision of the Personal Care Attendant (PCA), the only supervision documentation was for a visit on 9/15 and 9/17/14, on 10/13/14, and then 11/7 and 11/14/14. Due to skilled services being in place for this patient, the supervision of the PCA was due every 2 weeks. Per interview on 11/19/14 at 10:45 AM, the Assistant Director of Home Care confirmed that the supervisory visits were not completed as required, and the reason they were missed was a lack of coordination between disciplines serving this patient. The Occupational Therapist who set up the aide in the home, and was documenting supervision in September did not delegate the supervision task to the nurse after the patient was discharged from OT services after 9/22/14. 4. Per record review of Client # 1 on 11/18/2014, Skilled Nursing and MSW (Medical Social Worker) are checked off on the consent for treatment form signed by the client's legal guardian on 9/12/2014. There is no other mention of MSW being ordered, either on the actual referral or in the additional orders. There is no documentation to support why MSW was not followed up on by the admitting nurse. Staff report during interview on 11/19/2014 that this resident is followed by the local mental health group and that the entry for MSW on the consent form "was probably a mistake." Staff further confirm that there is no entry in the call log indicating the lack of need for MSW from the Home Health Agency since community resources are in place for that service.	G 144			
G 159	484.18(a) PLAN OF CARE	G 159			

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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	
G 159	<p>Continued From page 4</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the agency failed to ensure the plan of care covers all pertinent diagnoses, activities permitted, equipment required, types of services and any other appropriate services to meet the patient's need for 2 of 8 applicable patients (Patient #2 and #5). Findings include:</p> <p>1. Per record review of the intake information sheet on 11/18/14 Patient #2 was admitted on 10/28/14 with a diagnosis of colon cancer. Per observation of the patient on 11/18/14 at 11:30 AM, had noteworthy weakness and adaptive equipment that was not identified on the care plan. Per record review the patient was receiving CFC (Choices for Care) services and the care plan addressing moderate needs, which included assistance with housekeeping, cleaning, dressing, errands and a home exercise program (HEP). The care plan notes "client has poor balance" and "All other exercise -please use gait belt for exercise". It does not direct staff on how to safely assist with the adaptive equipment or exercise equipment. Per interview on 11/18/14 at 2:13 PM the Nurse Manger stated that the case management was provided by COA (Council On</p>	G 159			

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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	
G 159	Continued From page 5 Aging) and that the CFC's ILA (independent living assessment) form notes that the patient had a CVA [stroke] and left-sided weakness, and staff are to follow the service plan. The nurse manager at that time acknowledged that there was no service plan available. S/he confirmed that the agency failed to ensure the plan of care covers all pertinent diagnoses, activities permitted, equipment required or types of services provided. Also See State findings H-1606 2. Per review on 11/18/14 the referral for home health services for Patient # 5 Included the request to have a Medical Social Worker (MSW) conduct an evaluation of potential social and emotional factors associated with Patient #5's present health condition and care needs. At the time of a joint home visit with agency staff on 11/18/14, the surveyor was informed by a family member presently providing continuous care to their parent (Patient #5), they would benefit from the assistance of a MSW. Although the HHA had received the referral on 10/16/14 requesting the services of a MSW, a visit was never made and it was not considered as part of the initial plan of care. Per interview on 11/18/14 at 2:10 PM, the Nursing Supervisor confirmed the request for MSW services at the time of referral did not get processed correctly and there was a failure in communication and coordination within the Agency regarding the intake of referrals and confirming the correct plan of care. Per interview on 11/19/14 at 9:40 AM, the MSW also confirmed s/he had not received notification for services to be provided to Patient #5 nor was there any request by other disciplines to request a MSW consult.	G 159			

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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	
G 166	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that physician verbal orders and the plan of care were signed in a timely manner for 1 of 19 patients sampled (Patient #6). Findings include:</p> <p>Per record review on 11/18/14, Patient #6 was admitted to services on 5/8/14 for therapy after having a fractured hip. The admission was completed by the Physical Therapist (PT) as no skilled nursing was ordered. The patient was discharged due to goals being met on 6/10/14. The verbal order for treatment by the PT and Occupational Therapist was given by telephone to the therapist on 5/12/14, that included frequency of visits and therapy goals, but was not signed by the doctor until 9/3/14. The 485 plan of care was completed by the PT for this patient, however the record showed that it was not sent to the doctor for a signature until the end of August, and returned to the agency with an MD signature on 9/3/14. Per interview on 11/19/14 at 9:55 AM, the Director of the agency confirmed that the verbal order for treatment and the 485 plan of care were not sent to the physician for signatures until over 3 months after the start of services.</p>	G 166			
G 229	484.36(d)(2) SUPERVISION	G 229			

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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	
G 229	Continued From page 7 The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to conduct supervisory visits of the Home Health aides at the required frequency for 1 of 16 patients sampled (Patient #3). Findings include: Per record review on 11/18/14, Patient #3 was admitted to agency services on 5/8/14, for aftercare for a fractured hip. The orders for service included Skilled Nursing, Physical Therapy, Occupational Therapy, and a Home Health Aide for assist with personal care. Per review of the supervision of the Personal Care Attendant (PCA), the only supervision documentation was for a visit on 9/15 and 9/17/14, on 10/13/14, and then 11/7 and 11/14/14. Due to skilled services being in place for this patient, the supervision of the PCA was due every 2 weeks. Per interview on 11/19/14 at 10:45 AM, the Assistant Director of Home Care confirmed that the supervisory visits were not completed every two weeks as required.	G 229			
G 230	484.36(d)(3) SUPERVISION If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every	G 230			

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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	
G 230	Continued From page 8 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to conduct supervisory visits of the Home Health Aide every 60 days as required for 1 of 16 patients sampled (Patient #7). Findings include: Per record review on 11/18/14, Patient #7 was admitted on 5/27/14 as a most recent date of admission. The patient was on the Choices for Care program, and was receiving personal care from a Home Health Aide and case management services with no skilled services ordered during this time. Per review of the supervisory visits of the Home Health Aide, there was one completed on 5/23/14, and then not again until 8/7/14, which was 16 days over the 60 day requirement for supervision of the aide. Per interview on 11/19/14 at 11:30 AM, the nurse who conducts the supervisory visits of staff confirmed that due to being very busy, was not able to complete the supervisory visit within the 60 day required timeframe.	G 230			
G 248	484.52(a) POLICY AND ADMINISTRATIVE REVIEW As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote	G 248			

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2014
NAME OF PROVIDER OR SUPPLIER CALEDONIA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 161 SHERMAN DRIVE 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	
G 248	<p>Continued From page 9</p> <p>patient care that is appropriate, adequate, effective and efficient.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview the agency failed to ensure that agency policies are reviewed annually to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Findings include:</p> <p>Per record review on 11/19/14 at 10:30 A the agency policies are located in an online shared drive and are listed as Northern Counties Health Care Policies in a program called Corridor Media. There are an extensive number of policies in the online manual and the agreement with the provider, Corridor states that the policies meet Federal standards and are updated annually. There are 2 dates at the bottom of each policy are April 2012 and a 2009 copywrite date.</p> <p>Per interview on 11/19/14 at 10:30 AM,with the Quality Assurance Coordinator (QAC), the agency has used the Corridor program for several years and there are not additional hard copy policy manuals in use or available. The QAC stated that the agency has been working on reviewing the policies to adapt them to the agency specifically and check that current practice is accurately reflected in policy. S/he stated that at the beginning a number of individuals, who no longer work at the facility, chose policies to review however s/he has no records or accurate information about which policies have been reviewed. S/he stated that the Professional Advisory Committee (PAC) has been involved in the process which is on-going. She confirmed</p>	G 248			

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

PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
--	--	--	--

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

G 248	<p>Continued From page 10</p> <p>that the process for policy review is not actually structured and that policies are reviewed as issues arise.</p> <p>In a follow up interview on 11/19 at 3:35 PM, during the overall agency QA interview, the QAC reconfirmed that there is no record kept of the policies that have been reviewed and revised except for the policies which have been sent to the PAC for review. S/he also stated that there is no structured process for policy review and no method of tracking the policy reviews.</p>	G 248		
-------	---	-------	--	--