
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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February 21, 2014

Sandy Rouse, Administrator
Central Vermont Home Health & Hospice
600 Granger Road
Barre, VT 05641-5369

Provider ID #:477003

Dear Ms. Rouse:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 20, 2013**.

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

Sincerely,



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

FK:jl

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VT477003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED 11/20/2013
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NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT HOME HEALTH & HOSPI	STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANGER ROAD BARRE, VT 05641
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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 on-site State Designation survey was conducted by the Division of Licensing and Protection on 11/18/13 through 11/20/13. The following regulatory violations were identified:	H 001		
H 824 SS=D	8.2(d) Skilled Nursing Services VIII. Skilled Nursing Services 8.2 The registered nurse shall: (d) Furnish those services requiring substantial and specialized nursing skill; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home health nurse failed to follow agency policy and procedures during the provision of a peripherally inserted central catheter (PICC) dressing change for 1 applicable patient. (Patient # 2) Findings include: On 11/19/13 at 12:15 PM the following observations were made: Upon arrival to Patient #2's home, Nurse #1, after sanitizing his/her hands was observed removing a stethoscope and blood pressure cuff from his/her nursing bag and proceeded to take Patient #2's blood pressure and pulse. After use, Nurse #1 failed to cleanse/disinfect the reusable items before returning them to his/her bag. Per agency policy Infection Control-Bag Technique/Section: 07.01 last updated 9/12 states the purpose of the cleaning of reusable items is to "...reduce the risk of cross-infection between patients via the visit bag and the supplies it contains". Nurse #1 was	H 824	The agency will hold our 21/14 annual Hi-Tech Skills Fair in January 2014. Topics to cover include but are not limited to: - Bag leg equipment technique - PICC line dressing change/extension tubing changes All nursing staff will be required to demonstrate competency in the above procedures. Nurse #1 has had bag technique + PICC line dressing change reviewed	11/21/13

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Sandra Rousseau, CEO
STATE FORM 6899 40YR11
F. Keen, RN MSN (Cont.)
2/20/14 TITLE DBA.
(X6) DATE 2/10/14
If continuation sheet 1 of 6

Division of Licensing and Protection

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NAME OF PROVIDER OR SUPPLIER
CENTRAL VERMONT HOME HEALTH & HOSPI

STREET ADDRESS, CITY, STATE, ZIP CODE
**600 GRANGER ROAD
BARRE, VT 05641**

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H 824	<p>Continued From page 1</p> <p>then observed preparing to change the extension tubing attached to Patient #2's double lumen PICC, however the nurse failed to establish a clean work surface prior to opening supplies. The patient had been sitting at a table with an oilcloth table cloth, no attempt was made by Nurse #1 to establish a clean work surface prior to preparing the equipment. Nurse #1 donned gloves, opened packaging, disconnected the extension tubing, cleaned the catheter lumens, attached new tubing and flushed the PICC. With the same gloved hands, Nurse #1 began to prepare the PICC dressing kit and loosened the transparent occlusive dressing but did not completely remove. Nurse #1 removed the gloves and failed to sanitize. Per agency policy Infection Control - Standard Precautions; Section: 07.16 section 6. d. 3. "Always perform hand hygiene after removing gloves". Nurse #1 applied sterile gloves and mask and proceeded to complete the removal of the transparent occlusive dressing. The nurse did not change gloves as per agency policy: Infusion Therapy - Peripherally Inserted Central Catheter/Maintenance and Management of Potential Complications: Section : 9.33: D. "Dressing change" which states after removing the transparent dressing "Remove contaminated gloves and don new sterile gloves." After completing the dressing change, Nurse #1 removed his/her gloves and failed to sanitize. Upon realizing s/he had missed a step when performing the dressing change Nurse #1 applied gloves and removed the transparent dressing. The nurse again removed the gloves, failed to sanitize and donned sterile gloves to apply a small disc to the PICC site and again applied a transparent dressing.</p> <p>Per interview on 11/20/13 at 3:20 PM, Nurse #1</p>	H 824	<p><i>with her, as well as PICC tubing change T.C. K. Campese 11/23/13 The Clinical Services Director will be responsible for monitoring compliance</i></p>	<p><i>FK</i></p>

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NAME OF PROVIDER OR SUPPLIER: CENTRAL VERMONT HOME HEALTH & HOSPITAL
STREET ADDRESS, CITY, STATE, ZIP CODE: 600 GRANGER ROAD, BARRE, VT 05641

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H 824	Continued From page 2 confirmed s/he failed to cleanse/disinfect the reusable equipment after use and prior to being placed back into his/her travel bag, noting "S/he sometimes cleans the equipment at the end of the day". The nurse further stated s/he did not have to change gloves after removing the transparent occlusive dressing because s/he had touched the underside of the transparent dressing which s/he still considered "sterile" which contradicts agency policy.	H 824		
H1707 SS=D	17.7 Patient Rights XVII. Patient Rights 17.7 A patient has the right to appropriate and professional care in accordance with appropriate standards of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview agency nursing staff failed to provide care in accordance with appropriate standards of nursing practice for 2 of 2 applicable patients (Patient #2 & #1) Findings include: Per Lippincott Manual of Nursing Practice, 8th Edition, Chapter 31, Infectious Disease page 1033 & 1034 "Fundamentals of Standard Precautions" states "Hand hygiene is the single-most important measure to reduce the risks of transmitting microorganisms" "It may be necessary to clean hands between tasks on the same patient to prevent cross-contamination of different body sites. 2. Wearing gloves does not replace the need for hand hygiene because gloves may have small, unapparent defects or	H1707	The agency will hold our Annual Hi-Tech Skills Fair in January 2014. Topics to be covered include, but are not limited to: - Bag/equipment technique - PICC line dressing change All nursing staff will be requested to demonstrate competency in the above procedures by performing a return demonstration to the instructor.	2/11/14

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H1707	<p>Continued From page 3</p> <p>may be torn during use, and hands can become contaminated during removal of gloves."</p> <p>Per observations made on 11/19/13 at 12:15 PM an agency nurse failed to maintain basic standards of practice during the provision of a PICC line dressing change. Patient #2, who recently completed intravenous antibiotics for a septic knee, required a weekly PICC dressing change. Upon arrival to Patient #2's home, Nurse #1, after sanitizing his/her hands was observed removing a stethoscope and blood pressure cuff from his/her nursing bag and checked the patients blood pressure and pulse. After use, Nurse #1 failed to cleanse/disinfect the reusable items before returning them to his/her bag. Per agency policy Infection Control-Bag Technique/Section: 07.01 last updated 9/12 states the purpose of the cleaning of reusable items is to "...reduce the risk of cross-infection between patients via the visit bag and the supplies it contains". Nurse #1 was then observed preparing to change the extension tubing attached to Patient #2's double lumen PICC, however the nurse failed to establish a clean work surface prior to opening supplies. The patient had been sitting at a table with an oilcloth table cloth, no attempt was made by Nurse #1 to establish a clean work surface prior to preparing the supplies. Nurse #1 donned gloves, opened packaging, disconnected the extension tubing, cleaned the catheter lumens, attached new tubing and flushed the PICC. With the same gloved hands, Nurse #1 began to prepare the PICC dressing kit and loosened the transparent occlusive dressing but did not completely remove. Nurse #1 removed the gloves and failed to sanitize. Per agency policy Infection Control - Standard Precautions; Section: 07.16 section 6. d. i 3. "Always perform hand</p>	H1707	<p>2. pg 5-6 of 6</p> <p>The nurse in question has been instructed to establish a clean field and scissors must be sanitized prior to and after use.</p> <p>We disagree with the example related to the paper tape measure.</p> <p>The tape measure was stored in the pt's wound care box & never came in contact with the patient or the dressing change. The nurse used a Q-tip to measure the wound and then compared it to the tape measure for accurate measurements and then properly disposed of the Q-tip. The patient specific tape measure was then returned to the patient's Clean wound supply box.</p> <p>Te. K. Campus 12/23/13 The Cleanwound Services</p>	11/20/13

Director will be responsible for monitoring for compliance FX

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H1707	<p>Continued From page 4</p> <p>hygiene after removing gloves". Nurse #1 applied sterile gloves and mask and proceeded to complete the removal of the transparent occlusive dressing. The nurse did not change gloves as per agency policy: Infusion Therapy - Peripherally Inserted Central Catheter/Maintenance and Management of Potential Complications: Section : 9.33: D. "Dressing change" which states after removing the transparent dressing "Remove contaminated gloves and don new sterile gloves." After completing the dressing change, Nurse #1 removed his/her gloves and failed to sanitize. Upon realizing s/he had missed a step when performing the dressing change Nurse #1 applied gloves and removed the transparent dressing. The nurse again removed the gloves, failed to sanitize and donned sterile gloves to apply a small disc to the PICC site and again applied a transparent occlusive dressing.</p> <p>Per interview on 11/20/13 at 3:20 PM, Nurse #1 confirmed s/he failed to cleanse/disinfect the reusable equipment after use and prior to being placed back into his/her travel bag, noting "S/he sometimes cleans the equipment at the end of the day". The nurse further stated s/he did not have to change gloves after removing the transparent occlusive dressing because s/he had touched the underside of the transparent dressing which s/he still considered "sterile" which contradicts agency policy.</p> <p>2. Per observation of a dressing change for Patient # 1 at 11:55 A.M. on 11/18/13 the Registered Nurse (R.N.) failed to establish a clean field and to assure that needed supplies were available prior to conducting the dressing</p>	H1707		

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H1707	<p>Continued From page 5</p> <p>changes.</p> <p>In addition, the RN failed to sanitize scissors that were used during the dressing change and re-used a [paper] measuring tape.</p> <p>Per interview on 11/18/13 at 3:45 P.M., the nurse confirmed that she had " not used a barrier for the supplies because the house is dirty and if I the supplies fell off [the barrier] I would have to start all over again". S/he also acknowledged that the scissors were not sanitized before or after use and that the items needed were on the patient's bedside. When asked if the paper measuring tape had been used for prior measurements the nurse answered 'yes'.</p> <p>Per interview on 11/18/13 at 4:05 PM the Nursing Supervisor, who was also present during the observation of the dressing change, confirmed the above findings that the nurse failed to follow appropriate standards of nursing practice for wound dressing changes.</p>	H1707.		
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