
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

September 18, 2013

Janet McCarthy, Administrator
Franklin County Hha
3 Home Health Circle Suite 1
St Albans, VT 05478-9737

Provider ID #:477016

Dear Ms. McCarthy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on September 5, 2013.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure

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

PRINTED: 09/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C. 09/05/2013
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY HHA		STREET ADDRESS, CITY, STATE, ZIP CODE 3 HOME HEALTH CIRCLE SUITE 1 ST ALBANS, VT 05478		
(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 143	Continued From page 1. understand the concerns, and had no notable memory/cognitive issues. No further safety concerns related to smoking were documented until 6/18/13, when the nurse made a home visit and found the patient sitting in a room with the door closed, smoking a cigarette with the oxygen on and the nasal cannula in place. The nurse immediately turned off the oxygen concentrator, and re-educated the patient regarding the fire safety issues related to this practice, and documented this in the electronic record. Agency policy regarding Fire Safety and Oxygen therapy for this type of incident instructs the staff to alert their supervisor, and they are to alert the physician and the oxygen vendor of the safety concern. Per telephone interview on 9/5/13 at 8:50 AM, the Clinical Nurse Manager confirmed that the nurse who discovered the patient smoking was supposed to alert the Clinical Manager, and a report made to the physician, and that neither of these were done for the second incident on 6/18/13.	G 143		
G 159	484.18(a) PLAN OF CARE 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. This STANDARD is not met as evidenced by: Based on record review and staff interview, the	G 159	<i>see attached</i>	

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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY HHA		STREET ADDRESS, CITY, STATE, ZIP CODE 3 HOME HEALTH CIRCLE SUITE 1 ST ALBANS, VT 05478		
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G 159	<p>Continued From page 2</p> <p>agency failed to assure that the plan of care included assessment/monitoring of a significant safety issue for one patient (Patient#1). Findings include:</p> <p>Per record review on 9/4/13, Patient #1 was admitted for home care for diagnoses that included COPD and Urinary obstruction that required the use of an indwelling catheter. S/he was on continuous oxygen therapy, and had a history of smoking cigarettes. Nursing visits were scheduled every other week and a home health aid twice per week to assist with personal care. On 4/4/13, the LNA providing services noted that the patient had a quarter sized wound on his/her leg. When questioned about this, the patient stated that they had been smoking with the oxygen cannula in place and running, and had accidentally touched the tubing with a lit cigarette, melting the tubing and burning their leg. The LNA filed out an incident report, and informed the nurse in charge of the patient. The nurse made a home visit the next day, went over the safety risks of smoking while using oxygen, and informed the MD of the incident. The patient was able to understand the concerns, and had no notable memory/cognitive issues. No further safety concerns related to smoking were documented until 6/18/13, when the nurse made a home visit and found the patient sitting in a room with the door closed, smoking a cigarette with the oxygen on and the nasal cannula in place. The nurse immediately turned off the oxygen concentrator, and reeducated the patient regarding the fire safety issues related to this practice, and documented this in the electronic record. Per review of the plan of care for this patient, there was no revision made to indicate this was a concern, other than smoking cessation and safety</p>	G 159		

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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY HHA	STREET ADDRESS, CITY, STATE, ZIP CODE 3 HOME HEALTH CIRCLE SUITE 1 ST ALBANS, VT 05478
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G 159	Continued From page 3 risk due to falls. Per telephone interview on 9/5/13 at 8:50 AM, the Clinical Nurse Manager confirmed that oxygen and fire safety is an assessment item that could have been included in the plan of care, and was not listed as a safety issue for this patient despite the history of unsafe practice.	G 159		
G 176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency nurse failed to assure that a safety issue was communicated to the Clinical Nurse Manager and the physician for one patient (Patient #1). Findings include:</p> <p>Per record review on 9/4/13, Patient #1 was admitted to home care for diagnoses that included COPD. S/he was on continuous oxygen therapy, and had a history of smoking cigarettes. On 4/4/13, the LNA providing services noted that the patient had a quarter sized wound on his/her leg. When questioned about this, the patient stated that they had been smoking with the oxygen cannula in place and running, and had accidentally touched the tubing with a lit cigarette, melting the tubing and burning their leg. The LNA filled out an incident report, and informed the nurse in charge of the patient. The nurse made a home visit the next day, went over the safety risks of smoking while using oxygen, and informed the</p>	G 176	<i>see attached</i>	

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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY HHA	STREET ADDRESS, CITY, STATE, ZIP CODE 3 HOME HEALTH CIRCLE SUITE 1 ST ALBANS, VT 05478
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G 176	Continued From page 4 MD of the incident. The patient was able to understand the concerns, and had no notable memory/cognitive issues. No further safety concerns related to smoking were documented until 6/18/13, when the nurse made a home visit and found the patient sitting in a room with the door closed, smoking a cigarette with the oxygen on and the nasal cannula in place. The nurse immediately turned off the oxygen concentrator, and re-educated the patient regarding the fire safety issues related to this practice, and documented this in the electronic record. Agency policy regarding Fire Safety and Oxygen therapy for this type of incident instructs the staff to alert their supervisor, and they are to alert the physician and the oxygen vendor of the safety concern. Per telephone interview on 9/5/13 at 8:50 AM, the Clinical Nurse Manager confirmed that the nurse who discovered the patient smoking was supposed to alert the Clinical Manager, and a report made to the physician, and that neither of these were done for the second incident on 6/18/13.	G 176		
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G143 COORDINATION OF PATIENT SERVICES

Action to be taken (date action to be completed):

Team managers will provide education to nurses and therapists at team meetings regarding the Agency's policy to notify a manager, physician and vendor (when applicable) when a safety is identified (October 15, 2013.)

Team managers will verify staff understanding through written competency assessment (October 31, 2013.)

Method to monitor effectiveness of plan: Audit all patients who are receiving oxygen therapy to assess compliance with agency policy regarding notification of manager, physician and vendor of safety concern for a period of two months. (December 31, 2013)

Person responsible: Elizabeth Lavoie, RN

G 159 Plan of Care

Action to be taken (date action to be completed): Agency will activate fire and safety assessment module in electronic health record to be completed during assessments and reassessment (September 23, 2013.)

Method to monitor effectiveness of plan: Audit all patient records who are receiving oxygen therapy to assess compliance with requirement to complete fire and safety assessments at required intervals (December 31, 2013.)

Person responsible: Elizabeth Lavoie, RN

G176 DUTIES OF THE REGISTERED NURSE

Action to be taken (date action to be completed):

1. Team managers will provide education to nurses at team meetings regarding the Agency's policy to notify a manager, physician and vendor (when applicable) when a safety concern is identified and to update the plan of care as indicated (October 15, 2013.)
2. Agency will activate fire and safety assessment module in electronic health record to be completed during assessments and reassessment (September 23, 2013.)

Method to monitor effectiveness of plan: Audit all patients who are receiving oxygen therapy to assess compliance with agency policy regarding notification of manager, physician and vendor of safety concern for a period of two months. Audit will also include verification that plan of care has been update and includes oxygen safety. (December 31, 2013)

Person responsible: Elizabeth Lavoie, RN

Submitted 09.16.2013

Janet Lavoie