



Division of Licensing and Protection  
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July 1, 2014

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 **April 30, 2014**.

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

Sincerely,

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

FK:jl

Enclosure

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

JUN 17 2014

PRINTED: 06/05/2014  
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  04/30/2014
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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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(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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G 000	INITIAL COMMENTS	G 000		
G 121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, nursing staff failed to maintain professional standards of practice related to the risk of cross-infection between patients for 1 applicable patient. (Patient #1) Findings include:</p> <p>1. Patient #1, with a previous history of Breast cancer, was discharged home from the hospital on 3/27/14 after experiencing a wound separation secondary to abdominal surgery for ovarian cancer. Patient #1 also developed and was treated for C-difficile infection (a bacterial intestinal infection often the result of antibiotic use ) while hospitalized and subsequently once home developed thrush (a yeast infection in the mouth ) requiring additional antibiotics on 4/2/14. Patient #1 required skilled nursing visits initially twice daily and on 4/10/14 visits were changed to once daily. During each visit the nurse was responsible for performing a wet to dry packed dressing of Patient #1's large open abdominal wound. Per observation on 4/29/14 at 10:00 AM, Nurse #1 was observed changing the abdominal</p>	G 121	See attached	

*POC accepted by Emma F. Keeler RN MSN DBA 7/1/14*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 06-12-2014
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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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G 121	Continued From page 1 wound dressing and measurements of the wound. After the procedure, Nurse #1 removed from his/her travel bag a blood pressure cuff and took Patient #1's blood pressure and using his/her stethoscope listened to Patient #1's lungs. Upon completion of the the procedures, Nurse # 1 failed to cleanse/disinfect the blood pressure cuff prior to returning the cuff to the travel bag. Nurse #1 also failed to cleanse/sanitize the stethoscope and return the stethoscope to the travel bag but instead wrapped this reusable item around his/her neck and departed from Patient #1's residence.  Per the Agency policies and procedures Infection Control - Bag Technique Section: 07.01 states: "Considerations: 4. b. Keep items used on multiple patients clean by: ii Disinfecting parts that have touched the patient before putting them back in the bag such as, using alcohol and disinfectant wipes." The policy/procedure further states: "Equipment/Procedure: 7. Cleanse/disinfect reusable items before returning them to the bag. For example: a. Wipe diaphragm of stethoscope with an alcohol pad b. Wipe BP cuff with a disinfectant wipe. "	G 121		
G 170	484.30 SKILLED NURSING SERVICES	G 170	see attached	

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G 170	<p>Continued From page 2</p> <p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the Home Health Agency failed to ensure skilled nursing services were provided in accordance with the plan of care for 2 applicable patients. ( Patients #1, #2 ) Findings include:</p> <ol style="list-style-type: none"> <li>1. Patient #1 was discharged home from the hospital on 03/27/14 after experiencing a wound separation secondary to abdominal surgery for ovarian cancer. The plan of care upon discharge was to include skilled nursing visits initially twice daily. During each visit the nurse was responsible for performing a wet to dry packed dressing of Patient #1's large open abdominal wound. Per the 485/physician orders/certification and plan of care for 03/27/14- 05/25/14 the patient's wound was to be assessed for exudates, odor, pain, tissue color and redness of the wound. The extensive open wound was also to be measured weekly for depth, width, and length. Per record review, and confirmed with the clinical manager on the afternoon of 04/29/14, although a nurse measured Patient #1's wound on 03/27/14 at the time of admission, the next measurement was not conducted until 04/10/14, 14 days after admission on service which was not in accordance with plan of care.</li> <li>2. Per record review on 04/29/14, Patient #2 was admitted to Home Health services on 08/6/13 with a diagnosis of metastatic cancer, and had orders to receive skilled nursing services 1- 7 times per week for 9 weeks, and LNA services 3 times per week for 9 weeks. Per review of the visit</li> </ol>	G 170	See attached	

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G 170	Continued From page 3 schedule, and the nurse's notes, there were no skilled nursing visits made the week of 09/15-09/21/13, and again no skilled nursing visit made the week of 9/29-10/5/13. In the nurse's clinical note from a 09/13/13 home visit, the nurse wrote that the plan was to "Plan TC to Pt next week and HV if necessary". There was no documentation of a notification to the patient's doctor that the nurse was changing the scheduled home visit as ordered the week of 09/15/13, or any evidence that the patient was called on the phone that week as stated in the note. The clinical note by the nurse written on 09/25/13, after making a home visit, stated " Plan to see patient in two weeks or PRN". There was also no documentation of a contact with the patient's doctor to ask for a change in the frequency of skilled nursing visits or to notify the MD of a missed visit. Per interview on 04/30/14 at 10:15 AM, the Clinical Manager confirmed that the nurse had made the decision to miss the two home visits without notifying the doctor of either a missed visit or a request for a change to the patient's plan of care for less frequent skilled nursing services.	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by: Based on observation and staff interview, the nurse failed to re-evaluate the patient nursing needs for 1 applicable patient. (Patient #1) Findings include:	G 172	See attached	

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G 172	Continued From page 4 1. Patient #1, with a previous history of Breast cancer, was discharged home from the hospital on 3/27/14 after experiencing a wound separation secondary to abdominal surgery for ovarian cancer. On 4/2/14 Patient #1 was treated for thrush (a yeast infection in the mouth ) requiring an antibiotic. Per observation on 4/29/14 at 10:30 AM of a skilled nursing visit, Nurse #1 failed to re-assess Patient #1's oral mucous and tongue to assure there was no further evidence of the infection. It was also noted at the time of the visit, Patient #1 was experiencing edema of his/her feet. However Nurse #1 failed to conduct a brief evaluation of the patient's legs and feet to assess the degree of edema, question the patient regarding symptoms and possibly reporting findings to the physician. This failure also prevented the nurse from taking advantage of promoting preventative interventions/teaching to assist Patient #1 with the management of the present symptoms of lower extremity edema.	G 172		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE  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.  This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, the agency staff nurse failed to coordinate services and failed to inform the physician of changes in a wound status, services being provided, and unlicensed staff administering medications for 3 of 16 patients in the sample. (Patient #2, # 3 and #4) Findings	G 176	See attached	

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G 176	Continued From page 5 include:  1. Per record review on 04/28/14 Patient #3 who has a history of diabetic ulcers and multiple amputations had a change in wound status and LNA services with less frequencies as ordered but the physician was not notified of these changes. Per observation on 04/28/14 1:30 PM a sore on the right foot second toe had drainage and odor. Family stated that "it opened up last Friday". Review of the nursing note of 04/25/14 does not identify a new sore or that the physician was notified of this change. Per interview on 04/30/14 at 12:49 PM the RN stated " I saw it but I just didn't document it" S/he confirmed that the physician was not notified. Additionally, during the observation the family stated to the nurse surveyor that they "would like to have that second day back for the bath" and stated they were not sure why it got changed from twice to once weekly and that they never refused visits. Per record review the patient had physician's order for aides 2 x week during two recertification periods dated 12/19/13 until 04/17/14. During the time period once weekly aid visits were noted. There is no documentation that the physician was notified that the ordered visits were not made. Review of the 'unmade visit reports' during that time frame shows that patient either 'request/canceled/medical' or 'staff availability' or 'refused sub staff, or 'visit rescheduled'. Per interview on 04/29/14 at 10:43 AM the Clinical coordinator stated "I don't see the order [for once weekly] and you are correct the physician was not notified.  2. Per record review on 04/28/14 the staff nurse	G 176			

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G 176	Continued From page 6 failed to notify the physician that unlicensed staff were administering antibiotics to Patient #4. Per review of the Agency's policy and procedures states that unlicensed staff may be delegated to administer specific medication to specific patients after the nurse trains/educate those staff and obtains a physician order. The delegation training was documented however no physician's order was found detailing that the PCAs were administering the antibiotic Per interview on 04/28/14 at 1:05 PM the Long Term Care coordinator confirmed that the staff nurse did not obtain a physician's order for unlicensed staff to administer medications.  3. Per record review on 04/29/14, Patient #2 was admitted on 08/06/13 with physician orders for skilled nursing 1-7 times per week and home health aide 3 times per week. Per review of the record of aide visits to the patient, there were only two visits made the week of 08/25 -08/31/13, and only one aide visit to the patient during the week of 09/01 - 09/07/13. There was no evidence that the nurse or anyone in the agency had notified the physician of the missed aide visits. Per interview on 04/30/14 at 10:15 AM, the Clinical Manager confirmed that there was no documentation in the record to indicate that the nurse had notified the physician of the missed visits by the home health aide.	G 176		
G 228	484.36(d)(1) SUPERVISION  If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is,	G 228	See attached	

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G 228	Continued From page 7 physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.  This STANDARD is not met as evidenced by: Based on record review and interview the agency failed to assure O.T. (occupational therapy) supervisory visits occurred every 2 weeks, for 1 of 4 patients in the targeted sample receiving skilled services. (Patient #4) Findings include:  1. Per record review, Patient #4's most recent certification period dated 03/28/14 - 05/26/14 had orders for skilled O.T services, speech visits, and aides for personal care 1-2 x week. There were no every 2 week supervision visits by the O.T. for approximately 2 months. Per interview on 04/28/14 at 1:05 PM the Long Term Care Co-coordinator confirmed that the supervisory visits did not occur.	G 228		
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT  The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.	G 339	See attached	

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G 339	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to assure that a comprehensive assessment was updated and revised during the last 5 days of the 60 day certification period for one patient in the sample (Patient #2). Findings include:  Per record review on 04/29/14, Patient #2 was admitted on 08/06/13 for skilled nursing and home health aide services due to a diagnosis of metastatic cancer. The certification period as stated on the Plan of Care/485 was 08/06-10/04/13. Per review of the documentation, a recertification assessment was not completed 5 days before the end of the certification period, and was not completed until 10/09/13, which was 5 days after the patient's 60 day initial certification was ended. Per interview on 04/30/14 at 10:30 AM, the Clinical Manager confirmed that the nurse had not completed the assessment 5 days before the end of the initial certification period as required.	G 339			

**Franklin County Home Health Agency, Inc.**  
**Plan of Correction**

**G121 484.1 (c) Compliance with accepted Professional Standard**

*Action to be taken (date action to be completed):* Team managers will provide education to nurses, therapists and nursing assistants at team meetings regarding infection control practices. Agency will review current literature regarding best infection control practices and modify policies and procedures as indicated (July 18, 2014.)

*Monitoring:* Observational assessments will be made to verify that staff are following procedures.

**G170 484.30 Skilled Nursing Services**

*Action to be taken (date action to be completed):* Clinical Nurse Managers will provide education to nurses regarding wound care and adherence to the plan of care (July 18, 2014.)

*Monitoring:* Record audit will be performed to determine compliance with standard.

**G172 484.30(a) Duties of the Registered Nurse**

*Action to be taken (date action to be completed):* Clinical Nurse Managers will provide education to nurses regarding clinical assessment of the home care patient (July 18, 2014.) Clinical managers will review and revise, as necessary, patient assessment tools (September 30, 2014.)

*Monitoring:* Record audit will be performed to determine compliance with standard.

**G176 484.30 (a) Duties of the Registered Nurse**

*Action to be taken (date action to be completed):* Clinical Nurse Managers will provide education to nurses regarding situations requiring notification of physician (July 18, 2014.) Clinical managers will review and revise, as necessary, electronic record coding to clarify reasons visits are not made in accordance with the plan of care (August 30, 2014.)

*Monitoring:* Record audit will be performed to determine compliance with standard.

**G228 484.36 (d)(1) Supervision**

*Action to be taken (date action to be completed):* Clinical Managers will provide education to nurses and rehab therapists regarding supervision requirements of patients receiving home health aide services.

*Monitoring:* Record audit will be performed to determine compliance with standard.

**G339 484.55 (d)(1) Update of the Comprehensive Assessment**

Agency Comment: The Agency had identified this issue and had instituted progressive disciplinary action with the identified staff member. Nevertheless, the Agency appreciates the opportunity to take steps to prevent reoccurrence of this kind of concern.

*Action to be taken (date action to be completed):* Clinical Managers will provide education to nurses and rehab therapists regarding required timelines for completion of required timelines (July 18, 2014.) Agency will review and revise tracking tools to assist staff to comply with regulation (September 30, 2014.)

*Monitoring:* Record audit will be performed to determine compliance with standard.