

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

November 19, 2013

Kathleen Demars, Administrator
Lamoille Home Health & Hospice
54 Farr Avenue
Morrisville, VT 05661-9181

Provider ID #:477015

Dear Ms. Demars:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 30, 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

RECEIVED
Division of

PRINTED: 11/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	NOV 18 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED 10/30/2013
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NAME OF PROVIDER OR SUPPLIER LAMOILLE HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 54 FARR AVENUE MORRISVILLE, VT 05661
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G 000	INITIAL COMMENTS	G 000		
G 121	<p>An unannounced on-site Federal recertification survey was conducted on 10/28/13 -10/30/13 by the Division of Licensing and Protection. The following are Federal regulatory findings.</p> <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 and confirmed through staff interview, the agency nurse failed to comply with acceptable professional standards of practice during the provision of wound care for 1 of 2 clients in the targeted sample. (Patient #2) Findings include:</p> <ol style="list-style-type: none"> Per observation of a dressing change procedure on 10/28/13 at 11:45 A.M. for Patient #2, who was recently on antibiotics and had side effects from chemotherapy, the Registered Nurse (RN) failed to keep the wound free from potential contamination while dressing the wound. The nurse applied the antibiotic ointment directly from a large jar of Bacitracin, using a single tongue depressor, one end for one foot and the other end for the other foot. In addition the jar of Bacitracin was noted to be expired [May 2013]. Per interview on the morning of 10/29/13 the nurse confirmed that the best practice would be to put the antibiotic ointment on a gauze from which to apply the antibiotic to the wounds and to use one applicator for each foot. The nurse, confirmed that the dressing change was not done per 	G 121	<ol style="list-style-type: none"> Mandatory wound care in service for all SN + PT's scheduled for December 10, 2013. Wound care protocols from the VNAA manual reviewed with all SN/PT's at November 23, 2013 clinical staff meeting. Clinical Director to increase number of joint visits with SN/PT to observe wound care procedures. Supply closet being closely monitored for expired supplies by office staff when new supplies added to inventory. <p>G121 POC accepted 11/19/13 Simmons RN/AME</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathleen Campas RN</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11/15/13</i>
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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 professional standards and that the antibiotic was expired.	G 121			
G 144	<p>Ref: Basic Nursing -Theory and Practice ; Perry and Potter, The C.V Mosby Company : 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 confirmed through staff interview, the agency failed to assure effective reporting and coordination of client care and services for 1 of 6 patients in the sample (Patient #3). Findings include:</p> <p>1. Based on record review and staff interview, agency staff failed to show effective case conferencing had occurred for Patient #3. Per record review on 10/29/13 there are no Medical Social Worker [MSW] notes nor case conference notes regarding two incidents where the patient expressed self-harm. The Patient was admitted on 10/03/13 had a diagnosis of dementia and depression among other things. Per the nurse visit note of 10/08/12 states "per [spouse] [patient] would still like to kill [him/her] self". There are no further indications that the nurse either assessed the patient for actual self-harm or that the Agency's case manager and/or Elder Care were contacted. Per Agency's case manager note dated 10/10/13 states "....</p>	G 144	<p>1. Long term Care Supervisor has met and inserviced case managers on coordination of care. LTC Supervisor to attend weekly clinical staff meetings to ensure coordination of care.</p> <p>2. LTC Supervisor to audit case management visit notes on a weekly basis.</p> <p>3. Case managers to verbally in addition to written report client concerns and changes to LTC Supervisor on a daily basis.</p> <p>4. Executive Director to work with LTC Supervisor to ensure compliance.</p> <p>G144 Poc accepted 11/19/13 SEMMENSEN/PM</p>		

K. Demars RN - Executive Director
11/15/13

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G 144	Continued From page 2 [spouse] would like the MSW from home health..." Per interview on 10/30/13 at 8:40 A.M. the MSW was not aware of any concerns expressed by the patient's spouse nor was the MSW contacted by the nurse and/or case manager. Per interview at 9:00 A.M. the case manager confirmed there is no documentation in the client's chart of the reporting, assessing self-harm, exchange of information among staff nor coordination of patient's services.	G 144		
G 153	484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. This STANDARD is not met as evidenced by: Based on review of the agency records, the group of professional personnel were not meeting the requirement of annually reviewing the policies of the agency. Findings include: Per record review on 10/29/13, there was no documentation in the Professional Advisory Committee minutes that the policies governing the agency had been reviewed and approved in the last two years. The last documented review of all the policies of the agency was completed in 2009, and although a few individual policies had been reviewed at the subsequent meetings, a	G 153	1. Professional Advisory Committee to meet on 11/5/13 to review policies. 2. Board of Directors approved policies as presented at November 7, 2013 board meeting. After 11/5/13 PAC meeting, if any changes the board of Directors will be notified. 3. Annual calendar set up to ensure compliance with policy review and PAC requirements. 4. Executive Director to ensure compliance. G153 POC accepted 11/19/13 SEMMONS/PMC	

K Demaw RN - Executive Director
11/5/13

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G 153	Continued From page 3 total policy review had not been documented since 2009. Also in the Policy book for the agency, there was no date recorded of the last time the policies had been reviewed. Per interview with staff on 10/29/13 at 2:50 PM, the policies had been discussed by the Professional Advisory Committee at the March 29, 2013 meeting, however were not approved by the Board of Directors since the March 29th meeting, having been tabled at subsequent Board Meetings and not discussed and approved. Per interview on 10/29/13 at 3:15 PM, the Director of the agency confirmed that the agency's policies had not been reviewed and approved as required annually since 2009.	G 153		
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*K. Demas RN
4/15/13*

Division of Licensing and Protection

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H 001	Initial Comments An unannounced on-site State Designation survey was conducted by the Division of Licensing and Protection from 10/28/13 to 10/30/13. The following are State Designation regulatory findings.	H 001		
H 520 SS=D	5.9 Requirements for Operation V. Requirements for Operation 5.9 A home health agency shall comply with all applicable state and federal policies, guidelines, laws and regulations. In the event that State and federal regulations differ, the more stringent shall apply. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Agency failed to comply with State Regulations for 1 of 2 applicable patients in the sample. (Patient #1) Findings include: 1. Per the State of Vermont Choices for Care (CFC) 1115 Long-term care Medicaid Waiver Regulations, the requirement is that case managers make a 60 day 'face-to-face' visit for CFC patients. Per record review, Patient #1 did not receive case management on-site visits every 60 days for a 5 month period nor had a provider assessment to determine actual service hours based on need. The clinical record had evidence of visits for 11/13/12, 12/27/12, 02/25/13, 04/11/13 and 09/23/13. A 60 day visit was not made during the month of July 2013. In addition, per review of the CFC Moderate Need signed agreement (By the patient and by the	H 520	1. long term care Supervisor has implemented a wall chart to document all case management visits to ensure compliance. 2. Long term care supervisor has a process in place to assess client needs to determine amount of hours client will receive in addition to assessing amount of funding available. 3. Executive Director to ensure above processes are being utilized. H520 POC accepted 11/14/13 Semmons R/Ame	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kathleen Demaris RN

Executive Director

11/15/13

Division of Licensing and Protection

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H 520	Continued From page 1 Department of Aging and Independent Living] states "case management up to 12 hours per year and Homemaker services's up to 6 hours per week* actual service hours will be determined by service provider's assessment and based on need." The chart shows the Patient received two hours every other week from 12/02/12 - 04/27/13. The Patient now receives [from 04/27/13 -present] up to three hours per week. Also, a case management note dated 11/28/12 states that the patient called requesting additional hours. The case manager wrote "told [patient] we have two hours every other week available and ...s/he is getting the hours that are available" Per interview on 10/30/13 the CFC coordinator/supervisor stated that other than the State's assessment (ILA) to determine eligibility there is no formal provider's assessment to determine service hours based on the need. S/he confirmed the missed case management visits and the actual hours provided was not determined by the provider's assessment.	H 520		
H 623 SS=C	6.4(d) Organization, Services and Administration VI. Organization, Services and Administration 6.4 A home health agency shall establish a professional group of advisors to advise the home health agency on professional issues, to participate in the evaluation of the agency's program(s) and to assist the agency with the maintenance of liaisons with other health care providers in the community and with the home health agency's community information program. At a minimum, the professional advisors group shall: (d) Meet no less frequently than every six	H 623	1. Professional Advisory Committee to me every six months. Dates have been set into agency calendar to comply with regulation. 2. Executive Director to ensure compliance with meetings. H623 POC accepted 11/19/13 SEMMONS/PAC	

K. Demers RN 11/15/13
Executive Director

Division of Licensing and Protection

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H 623 Continued From page 2
months, and document each meeting with dated minutes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the agency failed to assure that the Professional Advisory Committee met every six months as required. Findings include:

Per review on 10/29/13 of the record of meetings by the Professional Advisory Committee, the meetings were held annually in 2011-2013. The records showed that the meeting was held once in 2011 on November 29th, once in 2012 on March 20th, and once in 2013 on March 29th. Per interview on 10/29/13 at 1:40 PM, the Director of the agency confirmed that the Professional Advisory Committee had only been meeting annually instead of every 6 months, and that the scheduled meeting for November 15, 2013 would be approximately 6 weeks late for the 6 month requirement.

H 623

H1802
SS=C 18.1(b) Quality Assurance and Improvement XVIII. Quality Assurance and Improvement

18.1 A home health agency shall establish an effective, ongoing, data-driven quality assessment and performance improvement program that reflects the full range of home health agency services, including those services furnished under contract or arrangement. The program shall:

(b) Measure, analyze, and track quality indicators, including adverse patient events,

H1802

1. QI. RN and clinical Director implementing a process to track adverse events and how to analyze data.
2. Ongoing education with SHP program to obtain up to the minute quality data.

*X. Dennis RN
11/5/13*

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H1802	<p>Continued From page 3</p> <p>existing or potential problems, and other performance indicators that assess quality, effectiveness and efficiency of agency services and operations;</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview the Agency failed to establish an effective Quality Assurance (QA) and improvement program for the full range of home health agency services and operations. Findings include;</p> <p>Per interview on 10/29/13 at 3:00 PM the Quality Improvement Coordinator (QIC) stated that currently the Agency is working on OASIS C (outcome assessment information set) and focusing on the accuracy for submission and receives feedback through the computer program call SHP. The QIC stated that a survey is sent to patients but was unable to state what the outcomes of the survey contained nor the rate of return. S/he did not indicate what other services or adverse patient events {if any} are currently being tracked or analyzed. When asked how does the Agency track quality indicators, existing or potential problems, other performance indicators that assess quality, effectiveness and efficiency the QIC stated "I guess it's an informal process". S/he confirmed that the Agency's QA program does not meet the criteria set forth in the regulations.</p>	H1802	<p>3. QI RN implementing multiple processes to track key quality indicators, existing and potential problems, and other performance indicators that assess quality, effectiveness and efficiency.</p> <p>4. QI RN to reach out to other QI home care programs to assist with the processes.</p> <p>5. Clinical Director and Executive Director to ensure compliance and progress in the Quality Assurance department.</p> <p>H1802 POC accepted 11/19/13 SEMMONS R/W/PMC</p>	

*K Demars RN
11/5/13*