



~~AGENCY OF HUMAN SERVICES~~
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
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Voice/TTY (802) 241-2345
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December 13, 2010

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

Provider ID #:477015

Dear Ms. Demars:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 1, 2010 through November 3, 2010.**

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

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VT477015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2010
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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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(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
H 001	Initial Comments An unannounced on-site survey for the Designation and Operation of Home Health Agencies was conducted by the Division of Licensing and Protection between 11/01/10 through 11/03/10. The following regulatory violations are related to this survey..	H 001		
H1410 SS=D	14.1 Clinical Records XIV. Clinical Records 14.1 A home health agency shall maintain a clinical record containing pertinent past and current findings in accordance with accepted professional standards for every patient receiving home health services. This REQUIREMENT is not met as evidenced by: The home health agency failed to maintain a current and/or accurate clinical record for 2 of 20 patients in the total sample. (Patients # 1,2) Findings include: 1. Per record review on 11/2/10 at 1 PM the agency failed to have a copy of an Independent Living Assessment (ILA) on file for Patient # 1, a self-directed Choices for Care client. The skilled nursing piece of the assessment for the Home-Based Service Plan (with a start date of 9/3/10) had been completed by the home health agency for the Central Vermont Council for Aging (CVCOA) who was the Case Manager for this patient. On 11/3/10 at 10:45 AM the Clinical Manager and the Office Manager confirmed that a copy had not	H1410	1. Copy of ILA for patient #1 is now in chart 2. Copies of all portions of ILA will be filed in patient charts. Nurse completing SN portion of assessment will assure copy is made and given to filing department. 3. Auditing department will audit LTC charts every six to twelve months to assure compliance. 4. LTC manager to verify audits are being done timely and charts corrected as needed.	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kathleen Demaro RN

TITLE
Executive Director

(X6) DATE

STATE FORM

6800

W4TK11

If continuation sheet 1 of 4

12/8/10

Division of Licensing and Protection

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H1410	Continued From page 1 been on file at the office until the afternoon of 11/2/10 when a copy was obtained from the CVCOA. 2. Per record review for Patient # 2 who was admitted to the Visiting Nurses Association (VNA) service on 07/22/10, the record contained inaccurate pertinent past and current medical information. The 485 plan of care dated 9/20/10 - 11/18/10, lists under Procedures to "change ileostomy 1-2 week". In addition, the Current Status section notes "management of urostomy". The Physician's History and Physical and referral notes states that the patient has an ileoconduit. The initial nursing note of 7/22/10 states the patient has an ileostomy while a subsequent nursing note of 10/27/10 states 'changed ureterostomy'. Per interview on 11/03/10 at 10:30 AM the Clinical Director confirmed that the patient's record contained inaccurate information.	H1410	1. Chart on patient #2 has been audited, and verified with MD of correct diagnosis. 2. Full time QA RN hired August 2010. RN to review referral information to 485 to visit notes. If errors found reported immediately to clinical director. 3. Increased amount of audits of charts occurring weekly.	
H1424 SS=D	14.4(i) Clinical Records XIV. Clinical Records 14.4 A home health agency's patient clinical records, whether written or electronic, shall contain at a minimum: (i) A copy of any advanced directive, Do Not Resuscitate Order (DNR) or Clinician's Order for Life Sustaining Treatment (COLST), if applicable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the agency failed to have a copy of the Advanced Directive in the the clinical chart for 1 of 20 patients reviewed. (Patient# 3.) Findings	H1424	4. Clinical Director to verify audits being done timely and accurately. - H1410 Poc Accepted 12/9/10 D Chittenden (P) Most RN 1. Copy of Advanced directive in patient # 3 chart. 2. Chart audit check list revised to double check electronic information versus hard copy in chart.	

*K. Demas RN
12/8/10*

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H1424	<p>Continued From page 2</p> <p>include:</p> <p>Per record review, the admission forms dated 10/02/09 in Patient # 3 's record, were signed as having an Advanced Directive, however there was no copy of the Advanced Directive in the patients's chart This was confirmed by the agency's Long Term Care Coordinator on the afternoon of 11/03/10.</p> <p>H1603 SS=D 16.3 Plan of Care</p> <p>XVI. Plan of Care</p> <p>16.3 A patient 's plan of care shall be in a format accessible to the patient.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the agency failed to have a plan of care for 1 of 20 patients in the total sample. (Patient # 3) Findings include:</p> <p>1. Per observation on 11/01/10 at 10:00 AM, Patient # 3 did not have a plan of care in the home chart directing the staff on patient care or services. Per interview at that same time, the spouse stated that 'some of the staff just sit and don't know what to do'. Per record review on 11/02/10 of the clinical record, the notes on 04/13/10, 06/29/10 and 10/26/10 did not have a copy of or the documentation regarding the patient's plan of care. In addition, the 10/26/10 visit note states "client needs a plan of care, will bring on next visit - struggles with telling personal care attendant (PCA) what to do".</p>	H1424	<p>3. Auditing department to audit LTC charts every six to twelve months to assure compliance</p> <p>4. LTC Manager to verify audits being done and charts corrected as needed.</p> <p>H1424 POC Accepted 12/11/10 D. Chittenden RN / Signature</p> <p>1. Plan of care in home of patient #3.</p> <p>2. Staff given written and verbal instruction to notify office from patient home if no Plan of Care is located.</p> <p>3. LTC manager and case manager to check each home visited to assure plan of care is in home, if not they also will notify office/LTC manager to report.</p>	

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H1603	Continued From page 3 Per interview on 11/03/10 at 11:00 AM the Long Term Coordinator confirmed there was no plan of care.	H1603	4. LTC manager to call patient homes, make increased home visits, check computer record to assure POC is accurate, up to date and in patients home. H1603 POC Accepted 12/1/10 D.Chittenden RN / A.Mestura RN		

K. Demas
12/8/10