

Division of Licensing and Protection  
103 South Main Street  
Waterbury VT 05671-2306  
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Fax (802) 871-3318

January 29, 2015

Kathleen Demars, Administrator  
Lamoille Hha  
54 Farr Avenue  
Morrisville, VT 05661

Provider ID #:471503

Dear Ms. Demars:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 3, 2014**.

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

Sincerely,



Suzanne Leavitt, RN, MSN  
State Survey Agency Director  
Assistant Division Director

SL:jl

Enclosure

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

JAN 22 2015

PRINTED: 12/11/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471503</b>	(X2) MULTIPLE CDNSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/03/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAMOILLE HHA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 790 MORRISVILLE, VT 05661</b>
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L 000	INITIAL COMMENTS	L 000		
L 557	<p>418.56(e)(4) COORDINATION OF SERVICES</p> <p>[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-]</p> <p>(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the Hospice agency failed to provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings for 2 of 11 patients in the sample. (Patient #2 and #3 ) Findings include:</p> <p>1. Per review of the medical record of Client # 3 on 12/01 2014 at 11:30 am, the Hospice failed to provide documentation to indicate that the Interdisciplinary group (IDG), which included the physician, social worker, and pastoral counselor were informed of a pharmacy's recommendation for care and services. Patient #3 was admitted on 04/21/14 and the nurse wrote that the pharmacy advised that some of the medications be discontinued. There is no evidence that this information was shared with the IDG either</p>	L 557	<p>L 557</p> <ol style="list-style-type: none"> <li>1. Increased education to 1/13/15 nursing staff regarding communicating with IDG team in a timely manner.</li> <li>2. IDG note from primary 2/20/15 RN being reformatted to be more specific.</li> <li>3. Nursing to communicate 1/13/15 with IDG team or to Clinical director who communicate with IDG. Communication will be noted in communication log confirming IDG team was notified of patients plan of care changes and updates.</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Kathleen Demass RN</i>	TITLE  <i>Executive Director</i>	(X6) DATE  <i>1/16/15</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.

L557 - L695 Plans of correction accepted 1/22/15 G. Coleman RN/PMC

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L 557	Continued From page 1 initially or at the IDG meetings, as those medications continued to be administered. Per interview on 12/03/14 at 11:59 AM the Clinical Director confirmed that the IDG team was not informed of the pharmacy recommendation.  2. Per review of medical record for Client # 2 on 12/02/2014 at 9:30 am, there is a nurses' note dated 10/28/2014 that indicates that Client #2 wanted a medication (Namenda) and supplements discontinued. The note further indicates that the issue will be discussed at the next IDG meeting, scheduled for 10/31/2014. Per review of the IDG minutes for the 10/31/2014 and subsequent meetings, there is no mention of the client request to discontinue medication and supplements. The fact that there was no follow through or IDG discussion was confirmed during interview with agency staff on 12/03/2014 at 10:30 am. Namenda was ultimately discontinued on 11/04/2014 but it was not a documented, coordinated effort.	L 557	<b>L557</b> 4. IDG meeting notes to 1/23/15 be approved by the clinical director or designated person to verify accuracy of notes taken after each IDG meeting. Clinical director to verify by signing note.	
L 591	418.64(b)(1) NURSING SERVICES  (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.  This STANDARD is not met as evidenced by: Based on record review and confirmed during staf interview, the Hospice failed to ensure that the care and services were provided in accordance with the plan of care for 1 of 11	L 591		

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L 591	Continued From page 2 applicable patients in the sample. (Patient #3) Findings include:  1. Patient #3 was admitted on 04/21/14 and was assessed as having potential skin integrity issues. The Hospice nurse failed, according to the plan of care, to assess an open area on the skin for nearly a two week period.. A nursing visit note on 11/14/14 stated the caregiver, who was not a Hospice employee, reported a "small open area on the sacrum". The nurse did not assess or observe the wound which would include information such as the actual size, descriptive qualities, type or classification and drainage. On 11/17/14 the visit note states " the care giver reports a small open area on the buttocks". The nursing visit on 11/21/14 noted "caregiver reports two small areas on sacral area", however there was no inspection of the wounds. The wounds were not assessed on the 11/24/14 & 11/28/14 nursing visits as well. Per interview on 12/03/14 at 11:59 AM the Clinical Director confirmed that the expectation would be for nursing to do an assessment through observation for all the information needed, which did not happen.	L 591	<b>L 591</b>  1. Increased and on-going <sup>1/13/15</sup> staff education regarding visualization and documentation of all wounds/skin lesions  2. Quality Nurse to audit <sup>2/1/15</sup> hospice charts while patient on service to assure wounds/skin lesions are being visualized and documented in accordance to best practice standards.	
L 629	418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES  (l) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.	L 629		

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L 629	Continued From page 3  This STANDARD is not met as evidenced by: Based on medical record review and staff interviews, the hospice failed to provide supervisory visits to 1 of 6 clients in the applicable sample (# 1). The specifics are as follows:  Per medical record review of Client # 1 on 12/01/2014 at 1:19 PM, there is no indication that the LNAs that were ordered by the MD were supervised by the RN at least every 2 weeks. Skilled nursing made visits on 10/16 and 10/30/2014, 11/06 and 11/13, 11/20 and 11/24/2014. There is no evidence to support that a supervisory visit was conducted by the nurse on 10/16/2014 or on 11/13/2014. This is confirmed by hospice staff during interview on 12/03/2014 at 11:35 am.	L 629	L629  1. Increased and ongoing education to RN's regarding accurate and timely documentation. 1/13/15  2. Increasing frequency of patient chart audits to ensure LNA supervision is being performed and documented. Quality Nurse to ensure audits completed. 2/1/15		
L 695	418.106(e)(2)(i)(A) LABEL DISPOSE STORAGE DRUGS  [At the time when controlled drugs are first ordered the hospice must:] (A) Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family;  This STANDARD is not met as evidenced by: Based on review of the agency's policy and procedure manual, the hospice failed to have written policies and procedures in place for the management and disposal of controlled drugs, so the hospice has no written directions to give to the client or their representative/family at the time that controlled substances are first used.	L 695	L695  1. Policy and Procedure has been written. To be presented at next board of directors meeting for discussion and approval. 1/27/15		

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L 695	Continued From page 4  Per review of the hospice policy manual on 12/02/2014, there are no policy or procedures evident that direct staff or families in the proper use and disposal of medications including controlled substances. This is confirmed during staff interview on 12/03/2014 at 12:00 PM.	L 695		