VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line:(888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 29, 2016

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 **May 18, 2016**.

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

Sincerely,

Suzanne E. Leavitt RN, MS

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

Enclosure

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

PRINTED: 06/29/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 477015 | | 05/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAMOILLE HOME HEALTH & HOSPICE | 54 FARR AVENUE<br>MORRISVILLE, VT 05661 |

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| G 000 | INITIAL COMMENTS<br><br>An unannounced onsite recertification survey and complaint investigation was conducted by the Division of Licensing and Protection from 5/16 - 5/18/16. The following are regulatory findings. | G 000 | | |
| G 144 | 484.14(g) COORDINATION OF PATIENT SERVICES<br><br>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews and staff interviews the agency failed to show in the clinical record case conferences were conducted to provide for effective reporting and coordination of client care for 1 of 12 Clients (#1) in the sample. Findings include:<br><br>1. Per record review Client #1's clinical record had no documentation of case conference that shows effective interchange, reporting, and coordination of patient care. Per the Hospital emergency room (ER) note dated 09/27/15 states "the patient was apparently told to change the gauze only if it soaks through. (patient) says the gauze did soak through but (patient) is unable to really see the area and it is too uncomfortable for [patient] to do own dressing changes. (S/he) tried calling VNA but they were not available today so came to the ER." There is no documentation in the client's progress notes or the chart's communication log that shows | G 144 | G144 - Patient called answering service at 12:43pm RN on call paged other nurse working at 12:46. That nurse called patient at 13:11pm to schedule visit and was informed she was not willing to wait for nurse to arrive and was going to the E.R.<br><br>On call RN's have been re-instructed to call patients back within 20 minutes of page. Answering service has been re-instructed to tell patients to call back if they have not heard from RN within 20 minutes.<br><br>Clinical Director to monitor call sheets weekly/Daily<br><br>7/1/16<br>K Demars RN<br><br>G144 POC accepted 7/14/16<br>Karen Campos RN | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 144 | Continued From page 1<br>effective interchange or coordination of care. A Call log, which is not part of the client's record and noted by the On-call Service, demonstrates that the client called several times on 09/27/15. The call log shows that Client #1 requested help for wound care, that no one had called back and then eventually the client could not wait for a visit the next day. The client called the primary doctor and was instructed to go to the ER. In addition, on 10/05/15 the nurse did not report to the physician a change to the wound dressing protocol. {See citation G-164}<br>The Clinical Manager on 05/17/16 at 1:50 PM confirmed that effective interchange, reporting, and coordination of patient care, was not documented in the client's chart. | G 144 | | |
| G 164 | 484.18(b) PERIODIC REVIEW OF PLAN OF CARE<br><br>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews the agency failed to provide evidence that the physician was notified promptly of changes in provision of ordered services for 1 of 12 sampled clients (Client #1). Findings include:<br><br>1. The staff nurse failed to notify the physician of a change in the plan of care regarding wound care. Per the recommendation by a certified wound nurse and ordered by the physician on 09/29/15 the client's wound dressing was for Triad ointment to the effected skin, a Mepilex dressing and cover with a pad. Per the visit note | G 164 | Clinicians instructed to check e-sign document tracking section of EMR each day.<br><br>Intake to follow up with a list of outstanding orders and address with primary staff to ensure MD orders are sent out timely.<br><br>Quality / Intake to ensure this process is followed and tracked. | 7/1/16<br>K. Demaro RN |



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| G 164 | Continued From page 2<br>on 10/05/15, demonstrates that the nurse "gave the patient Adaptic to use and instructed [Client #1] to continue with the regime [s/he] is now using and patient is more comfortable." The notes stated that the patient reported the Triad is too harsh but feels Zeroform and Adaptic [products for wounds] feels best. The client added the Mepilex and cover pad as well. There is no information found in the progress note or communication log note that the physician was apprised of these new changes. An interim physician order, written by staff, was faxed to the physician 13 days later. Per interview on 05/17/16 at 1:50 PM the Clinical Manager confirmed that physician was not updated promptly of changes in the provision of services | G 164 | G 164 POC accepted 7/14/16 Karen Campos RN | |
| G 224 | 484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE<br><br>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews the agency failed to ensure that written instructions were provided to the Licensed Nursing Assistant (LNA) for one patient with dressing changes (Patient #2) . Findings include:<br><br>Per record review, Patient #2 was at risk for the development of pressure ulcers due to his/her deteriorating condition, poor appetite, and limited mobility. According to the written instruction and notes in the record the resident had reddened | G 224 | RN instructed LNA as dressing protocols changed as documented in clinical note. Our current EMR does not allow us to show a progression of LNA plan of care changes<br><br>This agency is currently looking at a new EMR system to address these concerns.<br><br>7/1/16<br>K. Demaus RN | |



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| G 224 | Continued From page 3<br>and rashy areas of both upper thighs and gluteal folds. According to the LNA written instructions dated 4/1/13 the LNA was applying barrier cream and a Mepilex border to the areas. Later visit notes written by the skilled nurse state that on 12/12/13 the LNA was instructed in wound care for 2 wounds on the right and left sacrum buttocks and repeated the proper technique. At that time the wound protocol was wash wound with NS (normal saline) or after shower apply medihoney to the wound bed, apply skin shield to surrounding tissue, apply Mepilex border over wound bed. The LNA was to perform dressing changes twice weekly and the Skilled Nurse (SN) once a week. On 1/3/14 the patient is described as having 3 wounds- left medial buttocks, left buttocks, and right lateral buttocks. The wound care protocol remained the same but was to be done for all 3 wounds. On 2/25/14 the SN note stated that the wound has yellow slough and red granulating tissue. The wound protocol had changed to wash wound with NS, hypergel to wound bed, cover with a moist gauze, apply skin shield to surrounding tissue, apply Mepilex border to wound bed. LNA to perform dressing change 2 x a week and SN once a week. There is no evidence in the record of the LNA receiving any written instructions regarding the changes to wounds or wound protocol. In an interview on 5/18/16 at 2:00 PM, the Clinical Director confirmed that there are no updates of written instructions available. | G 224 | RN's to print out LNA plan of care at each change. Hard copy to be sent/delivered to patient home.<br><br>LTC Director to oversee this process.<br><br>7/1/16<br>K. Demars<br><br>G 224 POC accepted 7/14/16<br>Karen Campos RN | |



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