VERMONT

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
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

March 17, 2011

Barbara Keough, Administrator
Manchester Health Services
Po Box 1224
Manchester Center, VT 05255

Provider ID #:477009

Dear Ms. Keough:

Enclosed is a copy of your acceptable plans of correction for the Federal survey conducted on **February 2, 2011.**

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	477009	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH SERVICES	PO BOX 1224 MANCHESTER CENTER, VT 05255

(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
G 000	INITIAL COMMENTS An unannounced recertification survey was conducted by the Division of Licensing and Protection from 1/31/11 to 2/2/11. The following regulatory violations were identified.	G 000		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation and confirmed through staff interview and record review, the agency nurse failed to comply with acceptable professional standards of practice during the provision of wound care for 1 patient in the targeted sample. (Patient # 2) Findings include: 1. Per observation of a dressing change procedure for Patient # 2 on 02/01/11 at 11:20 AM the Registered Nurse (RN) failed to keep the wound free from cross contamination while cleaning an open wound. The nurse, took a saline soaked gauze and stroked from the top of the leg, over the open wound and then to the bottom of the leg, thereby not cleaning from a least contaminated area. Per interview with the clinical manager on 02/01/11 at 12:30 PM, s/he confirmed that the dressing change was not done per professional standards. Ref: Basic Nursing -Theory and Practice ; Perry and Potter, The C.V Mosby Company 1997	G 121	G 121 The Agency will take the following corrective actions: The involved RN was instructed by the Clinical Supervisor on wound care standards of practice. 2/3/2011 All registered nurses will attend an Agency In-service on principles of wound care. 3/18/2011 Following the in-service, the Clinical Supervisor will make home visits to observe the performance of each nurse performing wound care. 4/15/2011 At least annually, the Clinical Supervisor, to ensure compliance with wound care standards of practice, will make home visits to observe nurses performing wound care. 4/15/2011 G121 POC Accepted 3/15/11 D. Chittenden RN / RMcota RN	
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE	G 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara L. Keough RN
TITLE: Executive Director
(X6) DATE: 3/7/11

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.

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	477009	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH SERVICES	PO BOX 1224 MANCHESTER CENTER, VT 05255

(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
G 164	Continued From page 1 Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review and confirmed through interviews staff failed to conduct prompt physician notification when care plan changes were made for 2 applicable patient in the targeted sample. (Patient #1, #3) findings include: 1. Per record review on 01/31/11 at 9:00 AM the Patient #1's plan of care (485) and physician's signed orders dated 9/30/10 - 11/28/10 directed speech language therapy (SLP) for 1-2 visits per month. The Patient was visited by SPL on 10/08/10, however there were no further visits made by the SLP. A fax was sent 7 weeks later on 11/23/10 to the physician, by the nurse, stating the patient no longer wanted SLP services, however a signed copy has not been received as of the record review date. Per interview on 01/31/11 at 11:30 AM the Speech Language Therapist confirmed that the physician was not notified in a prompt manner . . 2. Per record review on 01/31/2011 Patient # 3 was referred to the Agency for Skilled Physical Therapy Services on 06/09/2010 the initial visit and assessment did not occur until 06/24/2010. There is no evidence in the medical record that the physician was notified of the delay in starting care. This was confirmed during an interview with the physical therapy staff on 02/01/2011 at 1:45 pm.	G 164	G164 The Agency will take the following corrective actions: In-service to reinstruct professional clinicians on the Standard, including, but not limited to, promptly notifying the physician of a delay in starting care, when a patient refuses care, and when a discipline has completed the Plan of Care. 3/18/11. Quarterly chart audit by QA coordinator to monitor compliance with Start of Care requirements, discharge notification to physician. 4/15/2011 G164 POC Accepted 3/15/11 D.ChAttendenRN/ RMcotaRN	
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS	G 166		

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	477009		02/02/2011

NAME OF PROVIDER OR SUPPLIER: MANCHESTER HEALTH SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 1224, MANCHESTER CENTER, VT 05255

(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
G 166	Continued From page 2	G 166		

Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.

This STANDARD is not met as evidenced by: Based on record review and staff interviews, the agency failed to assure that signed Plans of Care were received in a timely manner for 2 patients. (#5, #6). Findings include:

1. Per record review, Patient #5 had an original Certification/Start of Care date of 5/28/10 with a recertification date of 7/26/10. The Plan of Care/Physician Orders for the recertification date of 7/26/10 was signed by the physician on 8/31/10, and the Home Health (HH) Agency office stamped the physician signed and returned POC as received on 9/26/10. This date was two days after the next recertification period which began on 9/24/10.
Per review of the recertification period starting 11/24/10, the physician signed the Plan of Care on 1/4/11, and the HH Agency office stamped the POC as having been received on 1/18/11, only six days before the new recertification period began. Per interview on 2/2/11 at 9:10 AM, the Clinical Supervisor confirmed that the signed Recertification/Plans of Care were not returned to the agency in a timely manner.

2. Per record review, Patient #6 had an original Certification/ Start of Care date of 3/18/10. The physician signed the POC orders on 5/18/10, and the HH Agency office stamped the POC as

G 166

The Agency will take the following corrective actions to ensure timely return of the Plans of Care: (Activities are now in effect.)

The Secretary/Receptionist will log out the Plans of Care prior to sending.	2/22/2011
When the signed Plan of Care is returned, she will log it in.	2/22/2011
The Secretary/Receptionist will check the log weekly for POCs that have not been returned in a week and call the provider.	2/22/2011
Folders with POCs will be delivered to local physicians for signature twice a week, instead of weekly, if indicated.	2/22/2011
Whenever possible, the Plan of Care will be FAXed to the physician for signature.	2/22/2011
The Secretary/Receptionist will notify the Clinical Supervisor of Plans of Care that have not been returned in a timely manner.	2/22/2011
The Clinical Supervisor will then telephone the physician's office to request return of the POC.	2/22/2011

G166 POC Accepted 3/15/11
D.Chittenden RN | DMcotaRN

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

PRINTED: 02/15/2011
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
	477009		02/02/2011

NAME OF PROVIDER OR SUPPLIER: MANCHESTER HEALTH SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 1224, MANCHESTER CENTER, VT 05255

(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
G 166	Continued From page 3 received on 5/21/10, which was 7 days after the next recertification period started on 5/14/10. Per interview on 2/2/11 at 9:10 AM, the Clinical Supervisor confirmed that the signed Plan of Care for this patient was not returned to the agency in a timely manner.	G 166		
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the Agency failed to make an initial visit within 48 hours of the physician ordered Start of Care date for two patients.(#3, #4). Findings include: 1. Per record review, Patient #4 was referred to the Agency for Skilled Physical Therapy services on 3/12/10, with a verbal Start of Care date the same day. The Plan of Care developed by the Physical Therapist had the Start of Care date as 3/23/10, which was the date the initial therapy visit was made. Per interview on 2/1/11 at 1:45 PM, the Physical Therapist stated s/he works part time with the agency, and is not always available immediately when a referral is made. S/he confirmed that the initial visit was not made on 3/12/10 (per physician's start of care) but was made on 3/23/10, 11 days later. In addition, s/he confirmed that the physician was not notified that the start of care was not until 3/23/10. 2. Per record review on 01/31/2011, Patient # 3 was referred to the Agency on 06/09/2010 for skilled Physical Therapy. The start of care is	G 332	G 332 The Agency will take the following corrective actions: In-service for all professional clinical staff on the timeframe for the initial assessment visit. 3/18/2011 Notification of the physician if the visit is delayed or the patient/ family request a different start date. 3/18/2011 Quarterly Chart audit by the QA Coordinator to assess compliance. 4/15/2011 G332 POC Accepted 3/15/11 D. Chittenden RN | PMcotaRN	

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	477009		02/02/2011

NAME OF PROVIDER OR SUPPLIER: MANCHESTER HEALTH SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 1224, MANCHESTER CENTER, VT 05255

(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
G 332	Continued From page 4 dated 06/24/2010 when the first Physical Therapy visit and assessment were made. The lapse of time between the referral date and the initial visit was confirmed by the Physical Therapy staff during interview on 02/01/2011 at 1:45 pm. The documentation does not indicate that the physician was notified of the 15 day delay in starting care. This is also confirmed during interview with the Physical therapy staff on 02/01/2011 at 1:45 pm.	G 332		
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. This STANDARD is not met as evidenced by: Based on record review and confirmed through interview the agency failed to update the follow-up comprehensive assessment every 60 days for 1 of 16 patients in the targeted sample. (Patient #2). Findings include: Per record review conducted on 02/01/11 at 9:30 AM Patient # 2 had a follow up assessment completed outside of the 55 - 60 day window of time. The certification period ended on 01/08/11, however, the assessment was not completed until 01/10/11. Per interview during the afternoon on 02/01/11, the Performance Improvement	G 339	G 339 The Agency will take the following corrective actions: The registered nurse involved in filing the late Follow-up assessment was re-instructed by the Clinical Supervisor on the timeframes for completing all OASIS assessments. 2/4/2011 An in-service will be held to re-instruct all professional clinicians about the time-frames for completing OASIS assessments. 3/18/2011. The QA coordinator will monitor the timeliness of OASIS follow-ups when checking the OASIS prior to submission to data processing. 3/18/2011 Data Processing will monitor the CMS error summary report at least quarterly and report to the Clinical Supervisor. 4/15/2011 G 339 POC Accepted 3/15/11 D. Chittenden RN | P Mcota RN	

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

PRINTED: 02/15/2011
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
	477009		02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH SERVICES	PO BOX 1224 MANCHESTER CENTER, VT 05255

(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
G 339	Continued From page 5 Coordinator confirmed that the assessment was not completed within the last 5 days of the current 60-day certification period.	G 339		