

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

January 13, 2014

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 unannounced on-site recertification survey conducted on **December 11, 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

PRINTED: 12/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2013
NAME OF PROVIDER OR SUPPLIER MANCHESTER HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 1224 MANCHESTER CENTER, VT 05255		
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G 114	Continued From page 1 Authorization for Release of Personal Information, and Consent for Treatment. None of the documents contained lists of charges for services and/or patient liability. Per interview of the patients seen during home visits throughout the three days of survey none of the patients had in writing the charges for HHA services that will be covered or not covered over the course of treatment. Per interview on 12/11/13 at 9:40 AM the Clinical Director stated 'that probably most patients wouldn't care what the cost is because they are either Medicare or Medicaid. S/he further said we let them know the cost if they are private pay or want to continue services after discharge'. S/he confirmed that patients are not informed of liability prior to service.	G 114			
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on record review and staff interview the agency failed to document coordination of care activities provided to 1 Patient (Patient #9) The findings include; 1. Per review of the medical record for Patient #9, the client was readmitted to services on 12/4/13. The record indicates that services to be requested were physical therapy services. Per review of the OASIS, there was indication that	G 144			

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G 144	Continued From page 2 upon assessment the plan was that Client was in need of physical therapy services of 1 to 3/days per week for 8 weeks. Per review the face to face documentation signed by the physician, indicated that physical therapy services were being requested, but there was no written order or verbal order found in the record from the physician indicating amount and length of therapy services to be provided. Per review of the onsite visits and direct observation during and on-site visit to Patient #9 on 12/9/13, there was evidence that a therapist had provided onsite visits and provided therapy services since the readmission to services on 12/4/13. Per interview with the Clinical Director(CD) on 12/11/13, he/she reviewed the record and indicated that although the agency had spoken to the physician regarding the amount and length of physical therapy services to be provided to Patient #9, the CD was not able to provide written evidence in the medical record that there was coordination of care with the physician for therapy services.	G 144	G144 The Agency will take the following corrective action: A check box with text will be added to the Admission Assessment to document coordination of patient care with the physician, including services to be provided and frequency and duration of visits A clinical in-service will be held on 1/14/2014. Clinical staff will be re-instructed regarding documenting going the discussion of the Plan of Care with the physician and documenting the date the verbal order was received on the Admission Assessment. The Clinical Supervisor or designate will monitor compliance through review of the paperwork for new admissions.	1/14/2014
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE 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 staff interviews the home health agency failed to notify the physician when the POC (plan of care) was changed for 2	G 164		

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G 164	<p>Continued From page 3 of 12 patient's records reviewed (Patient # 2 and # 11). The findings are as follows:</p> <p>1. Per record review on 12/09/2013 at 3:15 PM, Patient # 2, who was admitted to home health services on 08/31/2013, had ordered LNA (Licensed Nursing Assistant) services to be provided 1-2 times per week to assist with showers and personal care. These services were changed from LNA to PCA (personal care attendant) with the completion of the "Choices For Care" application dated 05/05/2013. There is no evidence in the medical record to reflect that LNA services were ordered to be discontinued by the physician or that the physician was notified of this change (which began on 10/26/2013). The Clinical Coordinator confirms during interview on 12/11/2013 at 12:20 pm that the physician was not notified of this change in provided services.</p> <p>2. Per record review on 12/10/13, Patient #11 was admitted to Home Health Services after returning home with a healing hip fracture repair. The MD ordered Skilled Nursing, Occupational and Physical Therapy, and a Home Health Aide to assist with showers and other personal care. Per review of the certification period from 2/5-4/5/13, The Home Health Aide was going to the home twice per week until March 15, 2013, and then there were no more visits recorded for the aide. The notes by the nurse on 3/14/13 stated that the patient had progressed to be independent with showering, and that they no longer needed a Home Health Aide to assist. There was no evidence in the patient's record that the physician had been informed of the discontinuation of Home Health Aide services for this patient. Per interview on 12/11/13 at 10:45 AM, the Clinical Director confirmed that there was no</p>	G 164	<p>G164 The Agency will take the following corrective action: A clinical in-service will be held on 1/14/2014. Clinical staff will be re-instructed regarding notifying the physician of any changes in patient status, requiring a need to alter the Plan of Care. Specific instructions will be given to notify the physician when home health aide services are stopped during an episode due to the patient improving or when the patient becomes eligible for state-funded programs. Compliance will be monitored by chart audit of patients receiving home health aide and PCA services.</p>	1/14/2014 and on-going

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G 164	Continued From page 4 documentation by the nurse to indicate that the physician had been notified of the discontinuation of Home Health aide services for Patient #11.	G 164		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview the agency failed to obtain appropriate physician's orders before the start of care for 1 patient (Patient #9) The findings include; 1. Per review of the medical record Patient #9 was readmitted to services on 12/4/13. The record indicates that services to be requested were physical therapy services. Per review of the OASIS dated 12/8/13, there was indication that, upon assessment, the plan was that Patient #9 was in need of physical therapy services of 1 to 3/days week for 8 weeks. Review of the face to face documentation signed by the physician, indicated that physical therapy services were being requested, but there was no written order or verbal order found in the record from the physician indicating amount and length of therapy services to be provided. Per review of the onsite visits and direct observation during and on-site visit to Patient #9 on 12/9/13, there was evidence that a therapist had provided onsite visits and provided therapy services since the readmission to services on 12/4/13.	G 165	G165 The Agency will take the following corrective action: A clinical In-service will be held on 1/14/2014. Staff will be re-instructed regarding documenting contact with the physician for verbal orders for services on the Admission Assessment. However, this patient was admitted on 12/4/2013 and the survey was conducted on 12/9/2013. The Start of Care Assessment, which generates the 485, had not been reviewed by QA or data entered by our coder. There would not yet be a signed 485 in the chart.	1/14/2014

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G 165	Continued From page 5 Per interview with the Clinical Director on 12/11/13, he/she reviewed the medical record and confirmed that there was no written or verbal order for physical therapy service from the physician. The CD indicated that the physician was called and an order was obtained on 12/4/13 and that order was documented on the 485. The CD indicated when requested to provide the 485 that he/she could not provide the 485 to show evidence that the agency had a order from the physician. The CD indicated that the 485 was located somewhere else.	G 165		
G 233	484.36(e) PERSONAL CARE ATTENDANT EVALUATION REQU This paragraph applies to individuals who are employed by HHAs exclusively to furnish personal care attendant services under a Medicaid personal care benefit. An individual may furnish personal care services, as defined in §440.170 of this chapter, on behalf of an HHA after the individual has been found competent by the State to furnish those services for which a competency evaluation is required by paragraph (b) of this section and which the individual is required to perform. The individual need not be determined competent in those services listed in paragraph (a) of this section that the individual is not required to furnish. This STANDARD is not met as evidenced by:	G 233	G223 The Agency will take the following corrective action: PCA's who are providing care to Medicaid Choices for Care clients will receive the required 12 hours of annual in-services. The 12 hours will be provided for existing employees on a calendar schedule and for any new employees based on date of hire for the first year, and then per calendar schedule. Tracking of the 12 in-service hours	Begin 1/6/2014

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G 233	Continued From page 6 Based on review of 7 personnel files, the agency failed to assure that 1 of 2 employees providing personal care services under the Medicaid program, Choices For Care, had attended the 12 hours of annually required inservices to be considered competent to provide such care (Employee # 1). The findings are as follows: Per review of 7 personnel files beginning on 12/11/2013 at 10:45 am, there is no documentation in one of the files to indicate that 1 employee had met the requirements for 12 hours of annual inservice in order to provide personal care to clients. This is confirmed during interview with agency staff on 12/11/2013.	G 233	will be done by the Clinical Supervisor. Documentation of the in-service hours will be maintained in the PCA's personnel file.	Begin 1/6/2014
G 245	484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. This STANDARD is not met as evidenced by: Based on record review and interview the Agency failed to conduct in a timely manner an overall Annual evaluation of the Agency's total program. Findings include: 1. Per interview on 12/11/13 at 9:15 AM the Executor Director (E.D.) stated that all departments, including staff and the professional advisory group, gather information throughout the year and the Annual Report is presented for evaluation of the Agency's program to the full Board during the following February Meeting. Per review of the Annual Report present during	G 245		

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G 245	Continued From page 7 this February (2013), that would have contained record review, reports of the Agency's programs for the year of 2012, it was noted that the evaluation was dated 2011. The E.D. acknowledged that in coming year, February 2014, the Annual report will contain information from 2012 and not of the previous year of 2013. S/he confirmed the evaluations are greater than one year and not timely.	G 245	G245 The Agency will take the following corrective action: The Agency evaluation for 2012 and 2013 will be presented at the annual meeting of the Board of Directors in March 2013. Thereafter, the Agency evaluation for the previous year will be presented at the first full Board meeting of the following year.	3/2014
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