

Division of Licensing and Protection  
103 South Main Street  
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

March 5, 2015

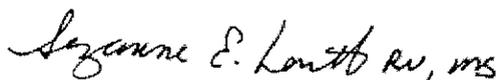
Ms. Robin Frasier  
VNA & Hospice Of SVHC  
1128 Monument Avenue  
Bennington, VT 05201

Dear Ms. Frasier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 10, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



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

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

MAR 04 2015

PRINTED: 02/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  477017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/10/2015
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NAME OF PROVIDER OR SUPPLIER  VNA & HOSPICE OF SVHC	STREET ADDRESS, CITY, STATE, ZIP CODE 1128 MONUMENT AVENUE BENNINGTON, VT 05201
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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) COMPLETION DATE
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G 000	INITIAL COMMENTS	G 000		
G 144	<p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews the agency failed to assure that the clinical record established that effective exchange, reporting and coordination of patient care did occur for one patient, Patient #3 (P#3) in a sample of 3. Findings include:</p> <p>Per record review Patient #3 (P#3) had an episode of self-harm on 11/21/14 when s/he admitted to the nurse that s/he had cut his/her wrist with a needle to help him/her focus and reduce anxiety. S/he denied any suicidal ideation at that time but later that evening cut his/her wrist with a razor in a suicide attempt. At the time of the first incident the patient did admit to being very depressed. There is no evidence in the record that the patient's attending physician and counselor had been notified of the incident of self-harm. The Case Manager/ Skilled Nurse (CM/SN) confirmed that the attending physician had not been notified of the incident and that the</p>	G 144	<p><i>Coordination of Patient Services</i></p> <p><i>The clinical record or minutes of case conferences establish that effective interchange, reporting and coordination of patient care does occur.</i></p> <p><i>Plan of Correction:</i></p> <p><i>(1) The Director of Home Care will review/revise the following policy as necessary by February 27th, 2015:</i> <i>SKILLED NURSING SERVICE</i></p> <p><i>Measurement:</i> <i>Review/Revised date on the policy</i></p> <p><i>(2) Beginning in March of 2015, the OI Specialists will coordinate with the Clinical Manager, the re-education (in verbal and written format) to all Nursing staff of the following policy:</i> <i>SKILLED NURSING SERVICE</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Quackenbush, CFO in absence of Ronald Cioffi* TITLE: \_\_\_\_\_ DATE: *2/26/15*

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 counselor had never replied to a message left on the counseling service's phone line. On 11/23/14 the patient was admitted to the Southwest Vermont Medical Center ER when the SN arrived at the residence to find the ex-spouse present and upset. At this time the CM/SN was informed of the first suicide attempt when the patient cut his/her wrist with a razor. The patient was brought to the ER and released the same evening. The next evening the patient needed to be moved after lying in the road in a suicide attempt. When the nurse arrived the patient admitted to feeling suicidal. The patient was held in the ER for a period of time without being admitted to the hospital or discharged from home care services. There is no evidence in the record of when the patient returned home or when the HH agency became aware of the return home. The first visit made was a Physical Therapy (PT) evaluation on 12/2/14. A SN visit was made on 12/4/14. There is no information in the record describing the patient's course in the ER or any coordination between the ER, the attending physician, the counseling service and the HH agency. The Skilled Services Manager and the Case Manager confirmed in interviews on the afternoon of 2/10/15 that there was no information from the ER regarding the patient's stay and that the exact date of his/her return home was not available. The patient also requested a visit from the Social Worker (MSW) on 2/12 15. No MSW visit was conducted and there is no evidence of follow-up by the CM or the Manager of Skilled Services who also oversees the MSW's. Both managers confirmed in interviews on the afternoon of 2/10/15 that there had been no follow-up to assure that the visit was conducted.	G 144	<u>Measurement:</u> • copies of Education handout • meeting minutes and sign-in sheet • staff not in attendance will be given written materials. completion date of March 20, 2015  (3) Auditing of eight (8) medical records for compliance with two Registered Nurse providing coordination of patient care will be completed by the Clinical Manager with a completion date of April 3, 2015.  COMPLETION DATE of G144 is APRIL 3rd 2015.  POC ACCEPTED 3/5/15 Margaret Nyman		

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G 164	Continued From page 2	G 164	<u>Periodic Review of Plan of Care</u>		
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 interviews the agency failed to assure that professional staff promptly alerted the physician of any changes that suggest a need to alter the plan of care for Patient #3 (P#3) in a sample of 3 reviewed. Findings include:  Per record review Patient #3 (P#3) had an episode of self-harm on 11/21/14 when s/he admitted to the nurse that s/he had cut his/her wrist with a needle to help him/her focus and reduce anxiety. S/he denied any suicidal ideation at that time but later that evening cut his/her wrist with a razor in a suicide attempt. At the time of the first incident the patient did admit to being very depressed. There is no evidence in the record that the patient's attending physician and counselor had been notified of the incident of self-harm and an identified increase in the patient's Depression. The Case Manager/ Skilled Nurse (CM/SN) confirmed that the attending physician had not been notified of the incident and that the counselor had never replied to a message left on the counseling service's phone line.	G 164 G 164	Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  <u>Plan of Correction:</u> (1) The Director of Home care will renew/revise the following policy as necessary by February 27, 2015: <u>PATIENT PLAN of CARE measurement:</u> <u>Review/Revised date on policy</u> (2) Beginning in March of 2015, the OZ Specialists will coordinate with the Clinical Manager, there-education (in verbal and written format) to all Nursing staff of the following policy: <u>PATIENT PLAN of CARE measurement:</u> • copies of Education handout • meeting minutes and Sign-in sheet • staff not in attendance will be given written materials Completion date of March 20, 2015 (3) observation of compliance will be confirmed by the Clinical Manager during home visits with the Registered Nurse with a completion date of April 3, 2015. COMPLETION DATE of 6164 is APRIL 3, 2015 POC ACCEPTED 3/5/15 Margaret [Signature]		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse prepares clinical and	G 176	<u>Duties of the Registered Nurse</u> The registered nurse prepares clinical and progress notes coordinates services, informs the physician and other personnel of changes in		

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G 176	<p>Continued From page 3</p> <p>progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews the agency failed to assure that the registered nurse prepared clinical and progress notes, coordinated services, informed the physician and other personnel of changes in the patient's condition and needs for Patient #3 (P#3) in a sample of 3 reviewed. Findings include:</p> <p>Per record review Patient #3 (P#3) had an episode of self-harm on 11/21/14 when s/he admitted to the nurse that s/he had cut his/her wrist with a needle to help him/her focus and reduce anxiety. S/he denied any suicidal ideation at that time but later that evening cut his/her wrist with a razor in a suicide attempt. At the time of the first incident the patient did admit to being very depressed. There is no evidence in the record that the patient's attending physician and counselor had been notified of the incident of self-harm. The Case Manager/ Skilled Nurse (CM/SN) confirmed that the attending physician had not been notified of the incident and that the counselor had never replied to a message left on the counseling service's phone line.</p> <p>On 11/23/14 the patient was admitted to the Southwest Vermont Medical Center ER when the SN arrived at the residence to find the ex-spouse present and upset. At this time the CM/SN was informed of the first suicide attempt when the patient cut his/her wrist with a razor. The patient was brought to the ER and released the same evening. The next evening the patient needed to be moved after lying in the road in a suicide</p>	G 176	<p><i>The patient's condition and needs.</i></p> <p><u>Plan of Correction:</u></p> <p>1) The Director of Home Care will review/revise the following policy as necessary by February 27, 2015: <u>PATIENT PLAN of CARE Measurement:</u> <i>Review/Revised date on policy.</i></p> <p>2) Beginning in March of 2015, the CI Specialists will coordinate with the Clinical Manager, the re-education (in verbal and written format) to all nursing staff of the following policy: <u>PATIENT PLAN of CARE Measurement:</u></p> <ul style="list-style-type: none"> <li>• copies of education handout</li> <li>• meeting minutes of sign-in sheet</li> <li>• staff not in attendance will be given written materials.</li> <li>• completion date of March 20, 2015</li> </ul> <p>3) observation of compliance will be confirmed by the clinical manager during home visits with the registered nurse with a completion date of April 3, 2015.</p> <p>COMPLETION DATE of G176 15 APRIL 3, 2015 POL ACCEPTED 3/5/15 Margaret Hyman RN</p>		

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G 176	Continued From page 4 attempt. When the nurse arrived the patient admitted to felling suicidal. The patient was held in the ER for a period of time without being admitted to the hospital or discharged from home care services. There is no evidence in the record of when the patient returned home or when the HH agency became aware of the return home. The first visit made was a Physical Therapy (PT) evaluation on 12/2/14. A SN visit was made on 12/4/14. There is no information in the record describing the patient's course in the ER or any coordination between the ER, the attending physician, the counseling service and the HH agency. The Skilled Services Manager and the Case Manager confirmed in interviews on the afternoon of 2/10/15 that there was no information from the ER regarding the patient's stay and that the exact date of his/her return home was not available. The patient also requested a visit from the Social Worker (MSW) on 2/12 15. No MSW visit was conducted and there is no evidence of follow-up by the CM or the Manager of Skilled Services who also oversees the MSW's. Both managers confirmed in interviews on the afternoon of 2/10/15 that there had been no follow-up to assure that the visit was conducted.	G 176			