

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

September 19, 2013

Ronald Cioffi, Administrator
Southwestern Vt Hospice Network
7 Albert Cree Drive
Rutland, VT 05702-0787

Provider ID #:471507

Dear Mr. Cioffi:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 28, 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: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2013
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NAME OF PROVIDER OR SUPPLIER SOUTHWESTERN VT HOSPICE NETWORK	STREET ADDRESS, CITY, STATE, ZIP CODE 7 ALBERT CREE DRIVE RUTLAND, VT 05702
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L 000	INITIAL COMMENTS	L 000	Plan of Correction 418.52 Patients' Rights	
L 501	<p>The unannounced self report investigations were conducted on 08/27/13 and 08/28/13 by the Division of Licensing and Protection. The following are Hospice regulatory findings.</p> <p>418.52 PATIENTS' RIGHTS</p> <p>The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.</p> <p>This STANDARD is not met as evidenced by: The Hospice failed to inform 1 of 4 patients in the sample of his or her rights regarding discharge. (Patient #1) Findings include:</p> <p>1. Per record review on 08/27/13 Patient #1 was admitted on 03/05/13 and discharged 04/26/13. On 04/23/13 the nursing visit was in regard to pain management as well as on 04/25/13. The record states "Routine visit to assess patient after discharge from RRMHC[hospital] on 04/23/13." In both visits the nurse was noted making assessments regarding pain and conversing. A case communication note dated 04/26/13 by the registered nurse, states "discharge summary- discharge date 04/26/13, last visit 04/25/13 continued discipline- n/a reason for discharge". The patient was given a discharge notice on day of discharge.</p> <p>Per interview the Hospice Director on 08/27/13 at 11:05 AM stated 'the nurse went to the house and the patient answered the door with a gun in [patient's] hand so we discharged under our policy for an emergency reason. The nurse contacted the supervisor the next day [24th] then [supervisor] called me and said s/he was concerned that nothing happened with this. So I</p>	L 501	<p>The patient has the right to be informed of his or her rights and the hospice must protect and promote the exercise of these rights.</p> <p>Plan of Correction: 1. The Associate Director of Hospice will review the following policies and make any necessary changes: Discharge for Reasons other than Death Rights of Hospice Patient Hand out Agency Handbook Agency Critical Incident policy Signed admission agreement Patient Rights and Responsibilities</p> <p>2. The Associate Director and Hospice Clinical Manager/ Quality Improvement Director will review any changes and re-educate all appropriate staff at the scheduled staff meeting on Oct. 2, 2013. Copies of the policies will be handed out to the staff. Meeting minutes will document the educational component. Per Diem staff and others not in attendance will be serviced by the Clinical Manager.</p> <p>3. Clinical Manager will S Emmon/E/Key, AW/MSA, DISA</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ronald J. [Signature]</i>	TITLE CEO	(X8) DATE 9/18/13
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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.

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L 501	Continued From page 1 talked with [human resource] and [quality assurance]." Furthermore, s/he stated" that we found out that the handgun was only a pelt gun that the patient used for target practice" Per review of the Hospice's Policy for Discharge for Reasons other than Death CES.D5 : 1 (f) . for cause, if the hospice determines that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that the delivery of care to the patient or the ability of the hospice to operate effectively is impaired Before the patient can be discharged for cause, the hospice: a. advises the patient that a discharge for cause is-being considered; b. makes a serious effort to resolve the problem(s) caused by the patient's behavior or the situation; c. ensures that the decision to discharge the patient is not related to the Patient's use of necessary hospice services; and d. documents in the patient's clinical record the problem(s) and the efforts made to resolve the situation 7. if it is an emergency discharge a phone call will be made to the hospice medical director and the attending physician to inform them of the reasons for the emergency discharge. Upon further review of the record there is no indication of an 'emergency' on 04/23/13 as there are no nursing notes, case communication or conference notes indicating any serious behavior nor on the subsequent visit of 04/25/13. A case communication note dated 05/10/13, 18 days later states "spoke with [human resource] and [quality assurance] about the incident with the decision to follow policy w/ABN [advance	L 501	Continued from page 1 observe at least one admission by each staff member to ensure compliance that the Bill of Rights is being explained and understood. 4. The Clinical Manager/Quality Improvement Manager will audit all admission records for compliance of documentation regarding the explanation of the Patient's Righats. 418.56(a) Approach to Service Delivery The hospice must designate an interdisciplinary group or groups composed of individuals who wrktogether to meet the physical, medical, psychosocial, emotional and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Inter-disciplinary group members must provide the care and services offered by the hospice and the group in its entirety must supervise the care and services. PLAN OF CORRECTION: 1. The Associate Director of Hospice will review the following policies and make changes as necessary to the following	Dec 2013

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L 501	Continued From page 2 beneficiary notice[discharge.. Medical Director who agreed with decision reported to state and follow up with a written report". Per interview on 08/27/13 at 12:09 PM the Hospice Director confirmed that the situation was confusing and the Hospice failed to inform the patient of his/her rights for discharge or resolution for continue services.	L 501	Continued from page 2 policies: Discharge for reasons other than death Coordination of Services Interdisciplinary Team Documentation Requirements		
L 539	Also see H-539 418.56(a)(1) APPROACH TO SERVICE DELIVERY (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. This STANDARD is not met as evidenced by: Based on record review and interview the Hospice did not designate two employees as part of the IDG (interdisciplinary group) who made care and service decision for 1 of 4 patients in the sample. (Patient #1) Findings include: 1. Per record review on 08/27/13 Patient #1 was discharged from Hospice services on 04/26/13 without the IDG care team involvement . A case conference note dated 05/10/13 states " a follow up due- 04/26/13 received call from on call nurse (that patient answered the door with a gun in hand, spoke with [quality assurance] and	L 539	2. The appropriate staff will be reeducated at the staff meeting Oct 2, 2013 regarding the responsibilities of the IDT in general and specifically related to coordination of care when a discharge is planned or an emergency discharge and the importance of timely documentation. Per Diem staff and others not in attendance will be inserviced by clinical manager. 3. The clinical manager will be responsible for chart audits on every discharge without a death to ensure that proper documentation is in place. 418.56(e)(4) Coordination of Care The hospice must develop and maintain a system of communication and integration in accordance with the hospice's own policies and procedures to provide for and ensure the ongoing sharing of information between all disciplines providing care services are provided directly	Dec. 2013	

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L 539	Continued From page 3 [human resource] about the incident with the decision to follow policy with advanced beneficiary notice discharge notice met with Medical Director who agreed with decision reported to state and follow up with a written report." Per interview the Hospice Director on 08/27/13 at 11:05 AM stated 'the nurse went to the house and the patient answered the door with a gun in [patient's] hand so we discharged under our policy for an emergency. The nurse contacted the supervisor the next day (24th) then [supervisor] called me and said s/he was concerned that nothing happened with this. So I talked with [human resource] and [quality assurance] and they told me to discharge per the emergency policy". Furthermore, s/he stated "that we found out that the handgun was only a pelt gun that the patient used for target practice". S/he acknowledged that there was no indication of an emergency as evident by lack of documentation in the record via case communication notes, nursing notes nor case conference notes. Additionally, s/he was unable to state why the nurse on 04/23/13 went into the home, completed assessments, sat for a period of time and conversed with the patient and that nursing staff were not notified of the alleged emergency and were allowed to continued to provide services in the home on 04/25/13. The Hospice Director confirmed at 12:09 PM that human resource and quality assurance persons were not part of Interdisciplinary group who provide the care and services offered by the hospice. Also see H-501	L 539	Continued from page 3 or under arrangement. Plan of Correction: 1. The Associate Director will review the following policies: Documentation Requirements Interdisciplinary Team Coordination of Services Patient Rights Patient Handbook Visit Safety policy 2. Appropriate staff will be educated at a staff meeting on Oct. 2, 2013 regarding timely communication and documentation. Staff will be inserviced as to the procedure to follow in what is considered to be an unsafe setting. Per Diem and others not in attendance will be inserviced by clinical manager. 3. Clinical manager will audit all discharge records without a death to ensure that communication and documentation has occurred. 418.104(e)(3) Discharge or Transfer Care The hospice discharge summary required by (e)(1) and (e)(2) must include a summary of the patient's stay including	Dec.2013
L 557	418.56(e)(4) COORDINATION OF SERVICES	L 557		

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L 557	Continued From page 4 [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (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. This STANDARD is not met as evidenced by: Based on record review and staff interview, Hospice staff failed to communicate information between all disciplines had occurred consistently regarding 1 applicable patient. (Patient #1) Findings include: 1. Per record review and interviews on 08/27/13 there are no case communication notes, nursing notes nor case conference notes indicating an emergency situation at Patient #1's home. Per interview the Hospice Director stated that s/he was aware of a situation regarding Patient #1 on 04/24/13, however, this is not noted in the chart. There are no notices to nursing staff of an alleged emergency, and they continued to provide services in the home. There was a case conference dated 5/10/13, 18 days after the the incident and discharge. The Hospice Director confirmed the failure to communicate information between all disciplines providing care and services. Also see H-539, H-501	L 557	Continued from page 4 treatments, symptoms and pain management, the patient's current plan of care, the patient's latest physician orders and any other documentation that will assist in post discharge continuity of care or that is requested by the attending physician or receiving facility Plan of Correction: 1. The Associate Director will review and make any changes if necessary: Discharge for reasons other than death without Death Policy Documentation Policy Coordination of Care 2. The appropriate staff will be reeducated regarding the requirements for documentation when a patient is discharged, at the staff meeting on Oct. 2, 2013. 3. The clinical manager will audit all discharges for documentation as required in the policy.	Dec 2013
L 684	418.104(e)(3) DISCHARGE OR TRANSFER OF	L 684		

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L 684	<p>Continued From page 5 CARE</p> <p>(3) The hospice discharge summary required by (e)(1) and (e)(2) of this section must include-</p> <ul style="list-style-type: none"> (i) A summary of the patient's stay including treatments, symptoms and pain management; (ii) The patient's current plan of care; (iii) The patient's latest physician orders; and (iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility. <p>This STANDARD is not met as evidenced by: Based on record review and interview the Hospice failed to have a discharge summary that included a summary of the patient's treatments, symptoms and pain management or any other documentation that will assist in post-discharge continuity of care for 1 of 4 patients in the sample (Patient#3) Findings include:</p> <p>1. Per record review Patient #3 was admitted to Hospice on 03/27/13 and was discharged on 05/01/13 to a Hospice House out of state. The last nurse note on 05/01/13 states "discharge without a visit -discharge summary TR." [TR means transfer] There is a list of medications and a consent form that were faxed to the Hospice House. There is no further information regarding the summary of treatments, symptoms, pain management or the plan of care. Per interview on 08/28/13 at 1:45 PM. the Hospice Director stated "that was a traveler [nurse] but you're right there is no discharge summary." The Hospice Director confirmed the expectation would be to have a discharge summary that included all care and services.</p>	L 684			