

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

June 10, 2013

Robin Frasier, Administrator
Vna & Hospice Of Svhc
1128 Monument Avenue
Bennington, VT 05201

Provider ID #:477017

Dear Ms. Frasier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 15, 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: 05/28/2013
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 05/15/2013
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NAME OF PROVIDER OR SUPPLIER VNA & HOSPICE OF SVHC	STREET ADDRESS, CITY, STATE, ZIP CODE 160 BENMONT AVENUE SUITE 17 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 An unannounced onsite re-certification survey was conducted on 05/13- 05/15/13 by the Division of Licensing and Protection. The following are Federal Regulatory findings.	G 000	84.18 Acceptance of Patients, POC, Med Super	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and staff interview the Agency failed to provide care according to written plans of care for 4 of 12 clients reviewed (Client #2, #3, #4, & #5) Findings include: 1. Based on record review on 5/13/13, Client #5 received services prior to getting specific signed physician orders. Client #5 was admitted to VNA services on 1/9/2013 for Physical Therapy (PT) services for diagnosis of status post surgical repair for spinal stenosis. Per review of the Physical Therapy Assessment completed on 1/9/13, the PTA indicated that Client #5 would need 1-2 PT sessions a week for 1 week and than need 1-2 PT sessions a week for 3 weeks. Per review of the medical record there was no evidence that facility had obtained an order from the physician for PT services that were administered to Client #5 from 1/9/13 until the client's discharge from services on 1/31/13. Per interview with the PT Clinical Coordinator on 5/15/13, s/he reviewed the medical record of	G 158	1. The Executive Director will send out a voicemail and written communication to all clinical staff by June 7 to remind them that the MD <u>must be contacted</u> to provide approval of the initial plan of care established on assessment; as well as for any changes to the plan of care during an open episode of care. These contacts must be documented in a clinical note in the patients EMR including order source (Telephone order with readback, faxed order or prescription found in home).- <u>Complete 6/5/13</u>	6.5.13
		G 158	2. The VNA intake and leadership staff will conduct a Process Flow Map by July 14 to examine the intake referral process from initial referral contact through initials visits for <u>all ordered disciplines</u> to identify the areas of variability and improve the consistency and reliability of the process and to ensure orders for multiple disciplines are completed.	
			3. (a.)The Clinical Information Coordinator currently performs an extensive Quality Assurance audit on all initial certification, recertification and resumption of care orders to assure they are accurate, complete and reflect the interventions to manage the comprehensive needs of the patient. As part of this review beginning June 10 2013, the	
			<i>POC accepted S. Emmis FKer RN MSN 6/10/13</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rolfe D. Frase</i>	TITLE <i>Executive Director</i>	(X8) DATE <i>6/7/13</i>
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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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G 158 Continued From page 1
Client #5 and confirmed that the signed order that was in the medical record for Client #5 was signed on 2/16/13 which was 6 days after Client #5 was discharged from receiving PT services. The PT Clinical Coordinator reviewed the medical records for Client #5 and confirmed that from 1/9/13 thru 1/31/13 there was no signed written or verbal order from the physician indicating the need to provide PT services to Client #5.

2. Per record review on 05/13/13 the Agency failed to follow the written care plan for Client #2, who has a history of diabetic neuropathy and chronic ulcers to the feet. The care plan states that staff should assess the wound on the right great toe, which is "open to air", as well as to follow the dressing procedure to the left foot. Per observation of a wound dressing for Client #2 on 05/13/13 at 12:45 P.M. the staff nurse applied a wound dressing to the left foot, however did not assess the right great toe wound. Per interview on 05/14/13 at 911 :05 A.M. the Clinical Director stated that "the nurse probably didn't check it because I think it is healed", but was unable to show documentation that the right toe was indeed healed. The Clinical Director acknowledged that even if the toe was healed, given the client's history, nursing should assess the feet at the time of visits and that they did not follow the current plan of care.

3. Per record review Client #3 services prior to getting specific signed physician orders. Client #3 had a physician order/referral dated 12/04/12 for a P-T evaluation. The client received the P-T evaluation visit on 12/06/12. The client also received PT visits on the 10th, 13th 18th and 20th

G 158 Clinical Information Coordinator will validate MD contact via clinical note for all planned orders and interventions by each discipline included on the certification, recertification and resumption of care orders. Any variance will be reported to the clinicians real time to ensure both MD contact and documentation are complete.

(b.)The VNA& Hospice did not have an established procedure for the QA of supplemental orders. Beginning 5/28/13 the Clinical Information Coordinator will review supplemental orders for accuracy prior to sending them to ensure there has been documentation of MD contact. Any variance will be reported to the clinicians real time to ensure both MD contact and documentation to support the addition/changes are complete.-New process initiated 5/28/13.

4. By June 30, 2013 the Clinical Coordinator of Quality and Education in collaboration with the Clinical Information Coordinator and Program Managers will coordinate an educational program for appropriate clinical staff on documentation of physician contact and agreement of POC in the EMR.

Monitoring/Measurement:
1. Measurement: Copies of the written "In Touch Today" re: the above announcement and a list of staff included on both the written and voicemail distribution lists will be recorded. 6.5.13

Rolui D. Fraxi *Executive Director* *6/7/13*

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G 158 Continued From page 2 of December 2012. Per interview on 05/15/13 at 10:45 A.M. the Physical Therapy Director stated that "although we had a referral there is no evidence that we communicated with the physician that we were planning on providing services, what type and the frequency of the visits". S/he confirmed that the physician was not notified.

4. Per record review of Client # 4 on 05/13/2013, the physician orders on the referral to the Home Health Agency are for PT and OT and Skilled Nursing services. Client # 4 was discharged from the hospital on 10/19/2012 with an entry that day that reads, "Services necessary: PT, OT, SN." Only skilled nursing was ordered and there is no evidence in either the electronic or hard copy of the medical to support that the therapy services were offered to the client and declined.

Agency staff confirmed during interview on 05/15/2013 at 10:38 am that the original hospital discharge forms dated 10/19/2012 included orders for PT and OT and that these services were neither offered or furnished to Client # 4.

G 173 484.30(a) DUTIES OF THE REGISTERED NURSE

The registered nurse initiates the plan of care and necessary revisions.

This STANDARD is not met as evidenced by: Based on observation, record review and interview the registered nurse failed to make necessary revisions to the plan of care for 1 of 5 clients in the sample. {Client # 2}. Findings

G 158 2. Copies of the sign in sheet, handouts, copies of the Process Flow Map and outcomes/process improvements will be recorded. Chart audits will be complete to assure follow through on all orders (see Measurement under number 3 below).

3. Ten percent of the active and ten percent of the discharged records per quarter will be audited by the Clinical Information Coordinator or designee beginning July 1, 2013 for 4 consecutive quarters through June 30, 2014 to assure: a. documentation of MD contact including order source for all new or revised orders is complete and; b. to assure that ordered services and interventions have been delivered as ordered. Variances will be discussed with individual clinicians 1:1 and variance patterns will be tracked for ongoing process improvement efforts.

4. Copies of the sign in sheet, and handouts will be recorded. Chart audits will be complete to assure follow through on all orders (see Measurement number 3 above).

G 173

Actions taken to correct deficiency:

G 173 1. The VNA has an established verbal and written communication system for important department and health system announcements entitled "In Touch Today". The Executive Director will provide clinical staff with weekly reminders for 3 months beginning June 10, 2013 to review and update Care Plans.

Robert D. Franke Executive Director

6/7/13

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G 173 Continued From page 3 include:

1. Per observation of a wound dressing for Client #2 on 05/13/13 at 12:45 P.M. the staff nurse applied a wound dressing to the left foot, however did not assess the right great toe wound. Per record review later that day, the care plan states that staff should assess the wound on the right great toe, which is "open to air", as well as to follow the dressing procedure to the left foot. Client #2 has a history of diabetic neuropathy and chronic ulcers to the feet.

Per interview on 05/14/13 at 9:11 :05 A.M. the Clinical Director stated that "the nurse probably didn't check it because I think it is healed". The Clinical Director that the care plan was not revised to reflect the client's current status or care needs.

G 173 The Clinical Coordinator of Quality and Education in Collaboration with the Clinical Information Coordinator will complete a staff educational program to reinforce the importance of revising and ending care plan interventions in the EMR with patient condition changes/order changes.

Monitoring/Measurement:

1. Copies of the written "In Touch Today" that include the above noted weekly reminders to update plan of care along with the distribution lists of staff included on both the written and voicemail distribution lists will be recorded from June 10, 2013 through August 12, 2013. 6.10.13

2. Copies of Educational Handouts, Meeting Minutes, and Sign in Sheets will be kept from staff educational programs. Staff not in attendance will receive written information and 1:1 follow up with signature to assure they received/understand the information. Quarterly chart audits will be performed on 10% open and 10% closed charts to compare assessment findings with care plan revisions to determine timeliness of revisions. Audits will be performed by the Clinical Information Coordinator or designee for a minimum of 4 consecutive quarters beginning with Quarter 4 of 2013 (July-Sept). Variances will be discussed with individual clinicians and patterns will be tracked for ongoing process improvement efforts. 7.1.13

Robin D. Trassin Executive Director

6/7/13



FAXED

PDF

6/7/13

Visiting Nurse Association & Hospice
1128 Monument Avenue
Bennington, VT 05201
Fax: 802-442-4919 Phone: 802-442-5502

Fax Cover Letter

The accompanying information is intended for the individual(s) identified below. If you have received this information in error, please immediately notify the sender by telephone to arrange for the return of the documents.

All information is required:

To: <u>Frances L. Keeler RN, MSN DBA</u>	From: <u>Robi Thoreau MS, DPT ED</u>
Date: <u>6/7/2013</u>	Location: <u>VNA + HOSPICE OF SVMC</u>
Company:	Company:
Fax Number: <u>802-871-3318</u>	Fax Number: <u>802-442-4919</u>
Re: <u>Deficiency Statements Response</u>	Phone Number: <u>802 442 5502 EXT 4565</u>
	Total Pages (including cover) <u>10</u>

Urgent For Review Please Comment Please Reply

Notes/Comments:

Please find the attached plans of Correction for the VNA + Hospice of SVMC. I will send the originals to you by mail. Please feel free to contact me with any questions. Thank you.

Sincerely,
Robi Thoreau MS, DPT, ED

Confidentiality Statement
The document accompanying this transmission may contain confidential information belonging to the sender which is legally privileged and protected by law. If you are not the intended recipient, you are hereby notified that any reading, disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. Violators may be prosecuted. If you have received this communication in error, please notify the sender immediately by telephone at the above listed number, or by contacting the Administrator-On-Call at (802) 442-5502.

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1128 Monument Avenue
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Dear Ms. Frasier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 15, 2013**.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

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H1418	Continued From page 1 record does not show all client care conferences.	H1418	<p>The second type is "CFC case manager". The intake Coordinator or Clinician will specify either the VNA Case Manager or Council on Aging to indicate the agency managing the patients CFC needs.</p> <p>2. (b.) The LTC Manager will populate all current VNA& Hospice CFC clients in the assignments screen by May 20. 5.20.13</p> <p>2. (c.) Beginning May 28th the VNA intake coordinator or designee will utilize the "patient master list" report in Allscripts EMR to identify active CFC clients who are referred to Homecare or Hospice, and document the CFC case manager in the Assignments screen on entering patient intake information into the EMR. 5.28.13</p> <p>3. (a.)The Clinical Manager of Homecare and Hospice in collaboration with VNA Administrative Assistant and Medical Records Clerk will file the historical paper Coordination of Care records in the patient hard charts by June 6, and will file the prospective COC paperwork in the hard chart following team meetings. 6.6.13</p> <p>3. (b) Beginning May 22, the Clinical Coordinator of Quality and Education in collaboration with the leadership team and VNA clinical staff will trial use of the Allscripts EMR for documentation of Coordination of Care during formal meetings on a minimum of 5 active patients at each meeting through June 19, 2013. The purpose of the trial is to determine the best 5.22.13</p>	
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Robin D. Franier

8899 XFH511
Executive Director

6/7/13

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H1418	<p>record document... A case conference...</p>	H1418	<p>location within the EMR and critical content for documentation of Coordination of Care Team Meetings. Findings from the trial will be utilized for staff education on the use of EMR for documentation of COC meetings beginning July 3, 2013.</p> <p>3. (c.) Beginning July 3, 2013 Documentation of Coordination of Care Team meetings will be completed within the EMR in a consistent location. Documentation content will be consistent and will minimally include disciplines present for the discussion and detail regarding the coordination of care among the disciplines involved. A sign in list for the meeting will indicate clinicians present. The log of attendance will be maintained by the Clinical Director.</p> <p>4. By June 30 2013, the Clinical Coordinator of Quality and Education will coordinate with the Program/Clinical Managers, the re-education (in verbal and written format) to applicable clinical staff on the following:</p> <ul style="list-style-type: none"> -Review of applicable Policies: Admission, Coordination of Care and Documentation/Record Keeping -Use of Allscripts EMR for documentation of Coordination of Care meetings for all patients in a consistent location and manner beginning July 3, 2013. -Addition of new CFC resource types within the EMR, role of the assignments screen. -Staff role in coordinating care and documentation of coordination both in and out of team meetings. 	
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Robert D. Franklin

Executive Director

*pg 3
6/7/13*

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H1418	<p>record does not reflect Allscripts Case Conferencing</p>	H1418	<p>Incorporated in orientation of all new clinical employees starting 6/30/13 use of Allscripts EMR to document coordination of care.</p> <p>Monitoring/Measurement:</p> <ol style="list-style-type: none"> Review/Revised dates will be placed on the policies on or before June 14, 2013. 6.14.13 (b) A Patient Assignment report will be run on or before June 7 to reflect the addition of the CFC case manager in patient records for all Active VNA Homecare and Hospice Clients. 6.5.13 (c) The LTC Manager will complete a quarterly chart audit beginning June 2013 (Q3) comparing 100% of the VNA and Homecare Active Census Assignments with the CFC service list to ensure the records reflect the client is receiving services for both programs. This audit will be completed for 5 Consecutive quarters through June of 2014 (a) Spot audit of a minimum of 10 active charts for either paper documentation or EMR documentation of COC meetings will be done on or before June 30, 2013. 6.30.13 (b.) Copies of the EMR documentation trial will be printed by June 19, 2013 and utilized as part of the staff education/training program re: use of EMR for documentation of COC meetings. 6.19.13 	
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Robert D. Frassin

Executive Director

*pg 4
6/7/13*

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H1418		H1418	<p>(c.) Measurement: The Clinical Coordinator of Education and Quality or designee will perform quarterly chart audits on 10% open and 10% closed charts to examine consistency of content and location of Coordination of Care meetings in the EMR for a minimum of 4 consecutive quarters beginning with Quarter 4 of 2013 (July-Sept). Variances will be discussed with individual clinicians and patterns will be tracked for ongoing process improvement efforts.</p> <p>4. Copies of Educational Handouts, Meeting Minutes, and Sign in Sheets will be kept from staff educational programs. Staff not in attendance will receive written information and 1:1 follow up with signature to assure they received/understand the information.</p>	7.3.13
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Robert Drasin

8899 XFH511
Executive Director

6/7/13 pg 5