



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) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

December 13, 2012

Judy Peterson, Administrator  
Visiting Nurse Association  
1110 Prim Road  
Colchester, VT 05446

Provider ID #:477000

Dear Ms. Peterson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 27, 2012**.

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

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN  
Licensing Chief

PC;jl

Enclosure



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

RECEIVED  
Division of  
PRINTED: 11/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  477000	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DEC 10 12 Licensing and Protection (X3) DATE SURVEY COMPLETED  C 11/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  VISITING NURSE ASSOCIATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1110 PRIM ROAD COLCHESTER, VT 05446
--	---

(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	G 000		
G 144	<p>The unannounced on-site complaints investigations were conducted on 11/26/12 - 11/27/12 by the Division of Licensing and Protection. The following are Federal regulatory violations.</p> <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 reviews and staff interviews the Agency failed to provide for effective reporting and coordination of patient care for 1 applicable client (# 1) Findings include:</p> <p>1. Based on record review and staff interview on 11/26/12, agency staff failed to document follow up to case conferences or that effective reporting had occurred for client #1. A nursing note dated 10/14/12 at 4:20 PM states " late entry for 10/08 - SN [skilled nursing] consulted MSW [medical social worker] on 10/08/12 regarding question of negligence, if client has back up assist for management in case of fire, ... SN encouraged to insist on skin assess next visit however, as not currently clear if [family] providing adequate physical care, MSW has worked with [family] before and would be available to meet with [family] if open". There is no timely MSW follow up for assessment of the caregiver's coping and ability to manage the</p>	G 144	<p>G 144- Coordination of Care</p> <ol style="list-style-type: none"> <li>1. Provide staff education on the importance of clear and timely documentation of case coordination between disciplines and with physicians. For example, noting specifically who was called and the subject discussed. Person responsible: Terry Paquin, Director Adult Home Care</li> <li>2. Review self-neglect policy and procedure with clinical staff. Person responsible: Terry Paquin, Director Adult Home Care</li> <li>3. Establish an audit system to verify this regulation is being met and incorporate into quarterly chart audits. Person Responsible: Michael Garrett, Manager of Quality &amp; Education</li> </ol> <p><i>Polacep led S. Emmons / Francis h Keen RN MSN OPA</i></p>	<p>1-25-13</p> <p>1-25-13</p> <p>1-25-13</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Theresa Paquin</i>	TITLE Director of AHC	DATE 12/3/12	(X6) DATE 12/7/12
--	--------------------------	-----------------	----------------------

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.

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

PRINTED: 11/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477000</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>VISITING NURSE ASSOCIATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1110 PRIM ROAD COLCHESTER, VT 05446</b>
---	---

(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 144	<p>Continued From page 1 complete care of client until 10/17/12. A case communication note dated 10/18/12 at 11:14 am states " SN (skilled nursing) received voice mail from [family] Mon 10/5/12 evening on cell phone, noting [family] decided to have physical therapy come in as client increasingly stiff, and possibly resuming the LNA's [licensed nursing assistant] . SN spoke with MSW [medical social worker] next day requesting s/he call [family] to discuss general increase in service as well as set up MSW visit, as [family] inappropriately persists calling SN on cell in evening hours". There is no clear documentation showing the interchange of information or coordination of care between the nurse and MSW on 10/05/12. In addition, a family member was resistant in allowing the client to receive nursing assessments and the monthly B-12 injections on 09/07/12 and skin assessment on 10/09/12 . Although the summary on the Form 485 dated for the period of 09/07/12 - 11/08/12 and a telephone message to the office nurse on 09/07/12 make note of the late administration of the B-12 injection, there is no documentation to establish that the physician received the message and made any necessary changes to the plan of care. Per interview on 11/26/12 at 4:37 P.M. The Clinical Manager stated "I would've liked to have talked with the nurse and most likely would have written a interdisciplinary note had I known. We usually would get an order for the MSW visit". S/he confirmed the lack of coordination of care and effective reporting to the physician.</p>	G 144		
G 170	<p>484.30 SKILLED NURSING SERVICES  The HHA furnishes skilled nursing services in</p>	G 170		

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

PRINTED: 11/28/2012  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477000</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/27/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>VISITING NURSE ASSOCIATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1110 PRIM ROAD</b> <b>COLCHESTER, VT 05446</b>		
(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 170	Continued From page 2 accordance with the plan of care.  This STANDARD is not met as evidenced by: Based on record review and confirmed by staff interview, the agency failed to follow the care plan for 1 applicable client (Client #1) Findings include:  Per record review on 11/26/12 Client # 1, is bedbound, unable to change position independently, with severe memory loss related to dementia, right shoulder pain with abduction and a recent history of a Pressure Ulcer [P.U.] on 05/09/12. Per the plan of care as noted by Form 485 dated 09/07/12 - 11/08/12, nursing was to make monthly visits to include; B-12 injections, teach/assess decubitus prevention, inspect skin for P.U., teach P.U. prevention measures, notify physician of new P.U., assess caregiver coping and ability to manage complete care of client. Per the nursing note of 09/07/12 the skin was not assessed and B-12 injection not given, as " family member did not want [client #1] to be disturbed by turning and assessing the skin, that the LNA [licensed nursing assistant] just left and wanted to defer the B-12 injection for another 1 1/2 weeks". A nursing note of 10/09/12 indicates the skin was not assessed for P.U. and states " non-blanchable pink area on right heel" and "[family] declines evaluation of back and buttocks and states there are no open/red areas". In addition, a nursing note dated 10/14/12 at 4:20 pm states " late entry for 10/08 - SN [skilled nursing] consulted MSW [medical social worker] on 10/08/12 regarding question of negligence if client has back up assist for management in case of fire,.... SN encouraged to	G 170	G 170- Following the Plan of Care  1. Provide staff education on the importance of following the plan of care, acting quickly when there are barriers to providing the care, and the communicating with your team manager and the physician when this occurs. Person responsible: Terry Paquin, Director Adult Home Care  2. Remind clinical staff about the various situations that the physicians should be contacted.  3. Establish an audit system to verify this regulation is being met. Person Responsible: Michael Garrett, Manager of Quality & Education	1-25-13  1-25-13  1-25-13	

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

PRINTED: 11/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477000</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/27/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>VISITING NURSE ASSOCIATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1110 PRIM ROAD</b> <b>COLCHESTER, VT 05446</b>
---	---

(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 170	<p>Continued From page 3</p> <p>insist on skin assess next visit however, as not currently clear if [family] providing adequate physical care MSW has worked w/ family before and would be avail to meet w/ family if open". There is no MSW follow up for assessment of caregiver coping and ability to manage the complete care of client until 10/17/12. The client was admitted on 10/18/12 to the hospital with a 5 cm stage IV sacral ulcer with bone visualized, purulent foul smelling drainage; candida rash of left arm, groin and buttocks, left shoulder anterior ecchymosis with left arm contracture and large decubitus ulceration. Per interview on 11/26/12 at 3:36 P.M. The Director of Adult Home Care confirmed that services were not provided in accordance with the plan of care.</p> <p>Also see Tag G-144</p>	G 170		
-------	--	-------	--	--