VERMONT

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) 241-2345
To Report Adult Abuse: (800) 564-1612
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November 18, 2011

J. Churchill Hindes, Administrator
Visiting Nurse Association
1110 Prim Road
Colchester, VT 05446

Provider ID #:477000

Dear Mr. Hindes:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 24, 2011**.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

OCT 26 2011

PRINTED: 10/11/2011
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477000 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 08/24/2011 |
|---|---|---|---|
| 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 |
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| G 000 | INITIAL COMMENTS<br><br>From 8/22/11 through 8/24/11 a recertification survey was conducted by the Division of Licensing and Protection. The following deficiencies were found. | G 000 | | |
| G 121 | 484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD<br><br>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.<br><br>This STANDARD is not met as evidenced by: Based on observation, record review and confirmed by interview, the Agency failed to adhere to professional standards of practice for dressing changes for 1 of 3 clients with wounds. (Client #3) Findings include:<br><br>1. Per observation of a dressing change for Client #3 on 08/22/11 at approximately 11:45 AM, the nurse failed to wash or sanitize his/her hands between glove changes. The nurse removed a soiled dressing and with the same gloves poured normal saline onto a 4x4 gauze to clean the wound. Per interview at 12:30 PM on 08/24/11, the nurse confirmed that s/he did not remove the same gloves that were used to remove the soiled when cleaning the wound. Per interview on 08/24/11 at 1:30 PM the Infection Control Coordinator confirmed that "it would be expected that after any dressing removal, the gloves are taken off, hands sanitized and new gloves are used to clean and dress the wound".<br><br>Lippincott Manual of Nursing Practice 8th addition, page 10 and 724. | G 121 | G 121 – 484.12(c)<br><br>1. A thorough review of hand hygiene and infection control procedures was completed during the annual infection control in-services conducted for all nurses, therapists and licensed nursing assistants during September and October with a special emphasis on dressing changes and times when to change gloves. Person responsible: Peg Haas-Slagle, RN, Infection Control Coordinator<br><br>2. A hand hygiene checklist will be included in the revised Adult Home Care Survival Guide that will serve as a regular reminder to staff. Person responsible: Ellen Leff, Director Adult Home Care.<br><br>3. Hand hygiene and infection control audit tool and process will be developed and implemented to monitor compliance. Person responsible: Michael Garrett, Manager Quality & Education<br><br>G121 POC accepted 11/3/11 Karen Campos RN | 10-12-11<br><br>12-31-11<br><br>11-04-11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ellen Leff — TITLE: Director of Adult Home Care — (X6) DATE: 10-21-11

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 | 484.14(g) COORDINATION OF PATIENT SERVICES<br><br>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.<br><br>This STANDARD is not met as evidenced by: Based on record review and staff interview, agency staff failed to follow agency policy and procedures when it failed to establish that coordination of patient care had occurred for 1 of 16 clients (Client # 1) who had experienced a significant mental health change. Findings include:<br><br>Per record review on 8/22/11 the nurse case manager documented that during a routine skilled nursing visit on 7/30/11 that Client # 1 expressed suicidal ideation.<br>Per agency policy on suicide prevention, agency staff is required to 'report to their supervisor or Program Director as soon as possible' (the same workday and usually within one hour) as well as document contact with the physician. In addition, the policy requires all Adult Home Care staff to seek consultation with the Psychiatric Team.<br><br>There was documentation that the nurse called the mental health hotline, the emergency "911", and arranged transportation for the client to be transferred to the hospital for an evaluation. However, there was no evidence that care coordination occurred within the agency with other members of the team. | G 144 | G144 – 484.14(g)<br><br>1. Review and, if needed, revise the Suicide Prevention Policy and Procedure. Person Responsible: Pat Donehower, Vice President Clinical Services<br><br>2. Educate all VNA clinical staff about the suicide prevention policy and procedure including communication protocols such as referrals and physician notification. Person Responsible: Pat Donehower, Vice President Clinical Services<br><br>3. Develop a procedure for reviewing patient records after a suicide ideation incident to assure the procedure was followed and documented. Person Responsible: Michael Garrett, Manager of Quality and Education | 10-26-11<br><br>12-31-11<br><br>10-31-11 |

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| | 477000 | | 08/24/2011 |

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

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| G 144 | Continued From page 2<br>Per interview on 8/24/11 at 1 PM with the clinical manager, s/he confirmed that there was no evidence in the nurses notes that there was no evidence that the Psychiatric Team was notified of Client #1's suicidal ideation and his/her transfer to teh hospital for an emergency mental health evaluation, demonstrating coordination of patient care. | G 144 | G144 POC accepted 11/3/11<br>Karen Campos RN | |
| G 164 | 484.18(b) PERIODIC REVIEW OF PLAN OF CARE<br><br>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview for 2 of 16 clients, agency staff failed to alert the primary physician to a significant change in the client's mental health. (Client # 1 & #4)Findings include:<br><br>1. Per record review on 8/22/11 the nurse case manager for Client # 1 documented that the client expressed suicidal ideation during a routine skilled nursing visit on 7/30/11. The nurse called the local mental health crisis number and was directed to call '911.' After phoning '911' the ambulance was called to transfer the client to the hospital ED for an immediate psychiatric screening for suicide. Agency Policy on 'Suicide Prevention" (Standard:Clinical Issues 10.8)d. It states that "Staff members must notify the physician of record when a client indicates suicidal ideation or intent.".<br>There was no evidence that the nurse case manager notified the primary physician regarding | G 164 | G164 – 484.18(b)<br><br>1. Revise the standard and nursing competency for PICC line care with specific guidelines for documentation and notification of physicians. Person responsible: Peg Haas-Slagle, Infection Control Coordinator<br><br>2. Have each Home Care Infusion Nurse complete the above competency. Person responsible: Peg Haas-Slagle, Infection Control Coordinator<br><br>3. Establish an audit system to verify the regulation is being met. Person responsible: Michael Garrett, Manager Quality & Education | 11-18-11<br><br>12-31-11<br><br>11-25-11 |

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| G 164 | Continued From page 3<br>Client # 1's mental health changes which was confirmed by the Clinical Manager on 8/23/11 at 4 PM.<br><br>2. Per record review on 08/22/11 the physician was not notified of Client #4's change in the peripherally inserted central catheter (PICC line). The nursing notes and assessments for the month of July 2011 as well as August 2nd and 9th visits documented the PICC line external length as 17cm. The nursing assessment of 08/18/11 noted a length of 8cm, a change of 9cm. Per interview on 09/23/11 at 3:17 PM the I.V. Coordinator stated "I would expect the physician to be notified" and confirmed the physician was not notified. | G 164 | G 164 POC accepted 11/3/11 Karen Campos RN | |