

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

April 18, 2013

Judy Peterson, Administrator
Vna Of Chittenden & Grand Isle Counties
1110 Prim Road
Colchester, VT 05446

Provider ID #:471500

Dear Ms. Peterson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 21, 2013**.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl



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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471500	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/21/2013
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NAME OF PROVIDER OR SUPPLIER VNA OF CHITTENDEN & GRAND ISLE COUNTIES	STREET ADDRESS, CITY, STATE, ZIP CODE 1110 PRIM ROAD COLCHESTER, VT 05446	RECEIVED Division of APR -5 13
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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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L 000	INITIAL COMMENTS An unannounced complaint investigation was conducted by the Division of Licensing and Protection on 03/21/13. The following are Hospice regulatory violations.	L 000	L 545 – Individualized plan of care	4-1-13
L 545	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: This STANDARD is not met as evidenced by: Based on record review and staff interview the Hospice failed to develop an individualized client-specific written care plan for 1 applicable client at the residency (Client #1) Finding include: 1. Per record review on 03/21/13 of Client #1's care plan, (as noted on the 485 dated 02/14/13) the plan has incorrect medications listed and contains no further care instructions to the unlicensed staff at the residential care home (RCH). Per further review, the Hospice's 485 states; Morphine Sulfate 20 mg/mL dispense syringe - 2 mg oral every 4 hours PRN [as needed] for pain or shortness of breath. It also identifies the use of milk of Magnesia 400 mg/5 mL as needed. Review of the RCH's MAR (medication administration record) and	L 545	1. A new process will be designed to coordinate and communicate the plan of care with all residential care homes including a new Initial Collaborative Hospice Plan of Care. This new form will indicate the VNA visit frequency and referrals and the nursing facility services and requested referrals. This form is in addition to the 485 that will be added to the record upon completion. Person responsible: Angel Means, Director End of Life Services 2. The new process will be reviewed at upcoming staff meetings and given to each of the residential care home caring for hospice patients. Person responsible: Angel Means, Director End of Life Services 3. Establish audit system to verify that the new process is in place and the new Initial Collaboration Hospice Plan of Care is being completed. Person Responsible: Michael Garrett, Manager of Quality & Education	5-3-13 5-10-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Alice Angel Means, Director EOL

TITLE
Director EOL

(X6) DATE
4/2/13

DOC accepted 4/16/13 F Keen RN MSN DRP

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 545	<p>Continued From page 1</p> <p>physician's telephone orders dated 02/14/13, indicate Morphine Sulfate 20 mg/mL give 2 mg/0.1 mL every 2 hours for mild to moderate pain or shortness of breath OR give 4 mg/0.2 mL every 2 hours for moderate to severe pain or shortness of breath. The milk of magnesia had been discontinued.</p> <p>Per review, the RCH's care plan has no noted services or treatment necessary for the palliation and management of the terminal illness and related conditions written by the Hospice nurse. The RCH's care plan dated 08/30/12 contains information that is not current and does not reflect the current functioning level of the client. As an example, the care plan notes oxygen use at 3 liters per minute, whereas, the current physician's orders notes "3 liters via nasal cannula, may increase up to 5 to maintain a saturation >90%". Furthermore, the RCH's current care plan notes use of Coumadin and fingersticks, which were discontinued by the physician's orders.</p> <p>Per interview on 03/21/13 at 3:30 P.M. the Hospice Director confirmed that the Hospice nurse did not write a care plan that contained clear individualized patient-specific services or medications to help the RCH's staff provide care.</p>	L 545		
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L 558	<p>see - 0558 and 0671</p> <p>418.56(e)(5) COORDINATION OF SERVICES</p> <p>[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-]</p> <p>(5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal</p>	L 558		
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L 671	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the Hospice failed to maintain correct and current information in the clinical record, at the residential care home (RCH) of 1 applicable Client. (Client #1) Finding include:</p> <p>1. Per record review on 03/21/13 at 1:00 P.M. of Client #1's medical record, current physician orders (485) had erroneous medications noted. The Medication list states " Morphine Sulfate 20 mg/mL dispense syringe - 2 mg oral every 4 hours PRN [as needed] for pain or shortness of breath. It also identifies the use of milk of Magnesia 400 mg/5 mL as needed. Per review of the MAR (medication administration record) and physician's telephone orders dated 02/14/13, at the RCH states, Morphine Sulfate 20 mg/mL give 2 mg/0.1 mL every 2 hours for mild to moderate pain or shortness of breath OR give 4 mg/0.2 mL every 2 hours for moderate to severe pain or shortness of breath. The milk of magnesia had been discontinued. In addition, the Client's medical record at the RCH had missing information. Per the nurse's progress notes dated 02/14/13, the note did not contain the time of the visit nor any clinical information as to the assessment. On 03/15/13 there is a hospice visit note without the time noted.</p> <p>Per interview at 4:00 P.M. the Hospice Director confirmed that the information in the medical charts were neither current nor correct.</p> <p>also see 0545</p>	L 671	<p>L 671 – Clinical Record</p> <ol style="list-style-type: none"> 1. Education will be provided to clinical staff regarding the importance completing medication reconciliation and maintaining an accurate medication profile for all Hospice patients as outlined in the VNAA Nursing procedure manual and the VNA Nursing Survival Guide. Person responsible: Angel Means, Director End of Life Services 2. Education will also be provided to the clinical staff regarding the requirements for clinical documentation particularly around progress notes, assessments, and the communication between staff in the residential care homes and Hospice. Person responsible: Angel Means, Director End of Life Services 3. Establish audit system to verify that the appropriate document is being made in a consistent manner. Person Responsible: Michael Garrett, Manager of Quality & Education 	<p>5-3-13</p> <p>5-3-13</p> <p>5-10-13</p>
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