

Division of Licensing and Protection
103 South Main Street
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 21, 2015

Jeanne McLaughlin, Director
Vna & Hospice Of Vermont And NH
205 Billings Farm Road Bldg 5
White River Junction, VT 05001

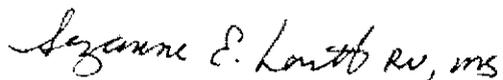
Provider ID #:471506

Dear Ms. McLaughlin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 28, 2015**.

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

Sincerely,



Suzanne Leavitt, RN, MSN
State Survey Agency Director
Assistant Division Director

Enclosure



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

PRINTED: 11/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471506	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2015
NAME OF PROVIDER OR SUPPLIER VNA & HOSPICE OF VERMONT AND NH		STREET ADDRESS, CITY, STATE, ZIP CODE 205 BILLINGS FARM ROAD BLDG 5 WHITE RIVER JUNCTION, VT 05001	

(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

L 000

An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 10/26/2015 and 10/28/2015. The following regulatory findings were identified:

L 523 418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT

L 523

The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.

See Attached

This STANDARD is not met as evidenced by:
Based on medical record review and staff interviews between 10/26 and 10/28/2015, the Hospice failed to assure that there was consultation with the other members of the interdisciplinary group (IDG), and that they considered the information gathered from the initial assessment to develop an individual plan of care within the first five days, for 5 of 13 clients in the applicative sample (# 1, 2, 3, 4, and 6):

1. Per record review on 10/26/15, the nurse failed to consult with the all other members of the IDG, to consider the information gathered from the initial assessment dated 10/16/15, so as a group, develop the plan of care [POC] for Client #2. There is evidence that the Medical Social Worker [MSW] was aware and agreed to the POC on 10/20/15, while the Chaplin noted agreement, 11 days later, on 10/26/15. There is no evidence that the physician was also polled regarding the POC. Per interview on 10/27/15 at 3:15 PM the

*acento POC attached 12.7.15
GC/AL*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Seamus Laughlin</i>	TITLE <i>President/CEO</i>	(X6) DATE <i>12/3/15</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 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 523	<p>Continued From page 1</p> <p>VP of Clinical Operations confirmed there was no evidence that showed the physician was made aware, contributed and/or agreed to the the POC</p> <p>2. Client #1 was admitted to Hospice services on 06/20/15. A comprehensive assessment was documented as completed on 06/20/15, however, the POC was not completed in consultation with the IDG, until 6 days later on 06/25/15. In addition, the POC updates and/or information from the 09/03/15 IDG meeting was not found. This was confirmed on 10/27/15 at 3:15 PM by VP of Clinical Operations.</p> <p>3. Per record review there was no evidence in the record of Client #6 that all members of the IDG (Inter Disciplinary Group) were involved with completing the comprehensive assessment and development of the plan of care to address all client's needs. On 10/27/15 at 3:15 PM the VP of Clinical Operations confirmed that there was no evidence available that the IDG was involved in the above.</p> <p>4. Client #4 was admitted to Hospice on 4/12/15 with a terminal diagnosis of lung cancer. Per review of Client #4's medical record, there was no evidence that all IDG members (Hospice Medical Director, Social Worker, RN and pastoral or other counselor), had collaborated within the first 5 days from the Start of Care to developed a plan of care to address the client's individual needs. It was not until 4/21/15 when the IDG documented the teams's review of Client #4's Hospice needs and plan of care. Per interview on 10/28/15 at 9:45 AM, the VP of Clinical Operations confirmed there was no evidence to confirm a collaboration had occurred within 5 days of Client#4's admission to Hospice.</p>	L 523	<p><i>See attached</i></p>	

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L 523	Continued From page 2 5. Client #3 was admitted to Hospice on 10/7/15 with a terminal diagnosis of bowel cancer. Per review of Client #3's medical record, there was no evidence that all IDG members had collaborated within the first 5 days from the Start of Care to develop a plan of care to address the client's individual needs. The only documentation identified was a note written by the Social Worker upon start of care. Per interview on 10/28/15 at 11:50 AM, the VP of Clinical Operations confirmed there was no evidence to confirm a complete collaboration had occurred within 5 days of Client#4's admission to Hospice.	L 523			
L 531	418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. This STANDARD is not met as evidenced by: Based on medical record reviews and staff interviews between 10/26 and 10/28/2015, the Hospice failed to assure that the initial bereavement assessment for 3 of 7 clients (# 4, 5, and 7) include a bereavement plan of care, sufficient to address the needs of the patient's family and other individuals focusing on the	L 531	See Attached		

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L 531 Continued From page 3

social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. The specifics are as follows:

1. Client #5 died on 08/04/14, and the chart review does not have evidence that a bereavement assessment was obtained and or provided to the family. Per interview on 10/26/15 at 1:08 PM the Bereavement Coordinator stated that a phone call is made and a letter is sent to the identified person(s), soon after the death of the loved one. There are additional mailings one, three, six, nine and twelve months plus a survey at thirteen months. Per record review and confirmed with the Bereavement Coordinator on 10/28/15 at 11:15 AM, there is no documentation that an initial bereavement assessment was completed for this client's loved ones.
2. Per record review in the afternoon of 10/26/2015, Client # 7 was admitted to Hospice services on 1/31/2015 and died on 4/09/2015. There is no evidence in the medical record that a bereavement care plan was formulated prior to his/her death or at the time of the initial assessment. This is confirmed during interview with the Bereavement Coordinator on 10/26/2015 at 1:08 PM and again during interview on 10/28/2015.
3. Client #4, admitted to Hospice on 4/12/15, died on 8/22/15. There was no evidence in the client's medical record that a bereavement care plan was developed prior to his/her death or after the client's death. Documentation only included

L 531

See attached

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L 531	Continued From page 4 attempts were made to contact the bereaved family after Client #4's death. Per interview during the morning of 10/28/15, the Bereavement Coordinator confirmed there was no evidence to support a bereavement care plan had been developed for Client #4 and identified family members of the deceased.	L 531		
L 642	418.78 VOLUNTEERS The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee. This STANDARD is not met as evidenced by: Based on interviews and medical record review the Hospice failed to consistently have a designated VNA Hospice employee supervise the volunteers. Findings include: 1. Per interview on 10/27/15 at 2:13 PM the Hospice Director (HSD) stated that the VNA Hospice has a contract with an outside agency that provides hospice volunteer services in the southern Vermont area. Currently there are approximately 6 clients receiving volunteer services that are not provided by the VNA Hospice. The HSD stated that supervision of the volunteers and hospice training is provided by their contracted agency. Per review of the process and the contract with this outside agency, the information states that the outside agency will supervise the volunteers. The HSD confirmed that supervision is not provided by a designated Hospice employee.	L 642	<i>See Attached</i>	
L 685	418.104(f) RETRIEVAL OF CLINICAL RECORDS	L 685		

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L 685	<p>Continued From page 5</p> <p>The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and staff interviews between 10/26-10/28/2015, the hospice failed to assure that the medical record was readily available on request by the survey team for the 13 medical records in the sample. Findings include:</p> <p>Per record reviews conducted by four surveyors throughout the three days of survey, the electronic medical records (EMR) were limited in regards to available information. There were a number of documents and information that were not viewable on the surveyor laptops, provided by the facility, that could be found by agency staff after searching, (for example, interoffice emails were on other system applications, which were not viewable through the main documentation program used by the surveyors. There was a considerable amount of time lost during survey while staff attempted to find and provide documentation and two staff members stated, while assisting surveyors that they were unsure why there were portions of the records that could not be accessed by the team.</p>	L 685	<p><i>See Attached</i></p>	

Survey Date October
26, 2015

ID Tag	Plan of Correction	Completion Date	Monitored by
L 523	Hospice failed to assure there was consultation with other members of the IDG		
Action taken to correct deficiency	Re-education for Hospice admitting nurses regarding documentation requirements for collaboration with Interdisciplinary Group (IDG) within 5 days of Start of Care (SOC).	10/31/2015	Cindy Scott, Hospice Director
Measure/s put in place or systematic changes put in place to assure deficiency does not recur	Audits for 100% of all SOC to ensure compliance for 30 days and then a minimum of 20% for another 60 days	10/28/15 thru 1/28/16	Cindy Scott, Hospice Director
Corrective actions that will be monitored so deficiency does not recur	Ongoing audits of minimum of 10% of all Hospice SOC.	Ongoing	Anne Fecto, Quality Supervisor
L531	Hospice failed to assure the initial bereavement assessment, including a bereavement plan of care was incorporated into the client EMR		
Action taken to correct deficiency	Re-education of designated 'Bereavement Coordinators' around requirement to complete assessment and develop plan of care as needed for all clients and designated bereaved.	10/31/2015	Cindy Scott, Hospice Director
Measure/s put in place or systematic changes put in place to assure deficiency does not recur	Audits for 100% of all SOC to assess completion of pre-bereavement and plan of care for 30 days and then a minimum of 20% for another 60 days.	10/28/15 thru 1/28/16	Cindy Scott, Hospice Director
Corrective actions that will be monitored so deficiency does not recur	Ongoing audits of minimum of 10% of all Hospice SOC.	Ongoing	Anne Fecto, Quality Supervisor
L642	Hospice failed to consistently have a designated VNA employee supervise contract volunteers.		
Action taken to correct deficiency	Volunteer Coordinator to provide supervisory oversight of all contract volunteers	Week of 11/16/15 and ongoing	Darcy Sylvestre, Volunteer Coordinator
Measure/s put in place or systematic changes put in place to assure deficiency does not recur	Volunteer Coordinator will be present at initial contract volunteer training	Week of 11/16/15 and ongoing	Darcy Sylvestre, Volunteer Coordinator

*POC unit
12.7.15
GC/SL*

	Audits for 100% of all contract volunteers to determine compliance with supervision for 30 days.		Week of 11/16/15 and ongoing	Darcy Sylvestre, Volunteer Coordinator
Corrective actions that will be monitored so deficiency does not recur	Audits for 100% of all contract volunteers to determine compliance with supervision for 30 days.		Week of 11/16/15 and ongoing	Darcy Sylvestre, Volunteer Coordinator
L642	Hospice failed to assure that the medical record was readily available on request for the survey team for 13 medical records			
	We take exception to the comment that there was a 'considerable amount of time lost during survey while staff attempted to find and provide ...' The comment re: two staff members stated unsure why portions of records were not available - only access to staff was Sheila Aubin and Cindy Scott - neither of them made this comment. We are requesting clarification on this tag.			
Action taken to correct deficiency	Doc Star has 9 licenses that are used on a daily basis by internal staff. In the future, a designated medical record staff with a Doc Star license will be available to the designated VNH survey lead during all future surveys to print required documentation. There is no reason for emails to be printed during a survey because all documentation is in the EMR.			Sheila Aubin, VP of Clinical
Measure/s put in place or systematic changes put in place to assure deficiency does not recur	Above		Oct-15	Sheila Aubin, VP of Clinical
Corrective actions that will be monitored so deficiency does not recur	Above		Oct-15	Sheila Aubin, VP of Clinical

*Doc amnt 12.7.15
GC/SJL*