

Division of Licensing and Protection
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Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

May 20, 2011

Jeanne McLaughlin, Administrator
Vna Of Vt & Nh
1 Hospital Court
Bellows Falls, VT 05101

Provider ID #:477002

Dear Ms. McLaughlin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on
April 20, 2011.

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

RECEIVED
Division of

PRINTED: 05/03/2011
FORM APPROVED
OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED 04/20/2011
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NAME OF PROVIDER OR SUPPLIER VNA OF VT & NH	STREET ADDRESS, CITY, STATE, ZIP CODE 1 HOSPITAL COURT BELLOWS FALLS, VT 05101
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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
G 000	INITIAL COMMENTS	G 000		
G 121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>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 3 of 4 patients with wounds. (Patient's # 1,2, & 3) Findings include:</p> <p>1. Per observation on 4/18/11 at 2:00 PM of a clean dressing change to Client # 1's venous stasis ulcers, for the left lower leg, the nurse failed to provide a clean barrier under the patient's leg during the dressing change. The area where the patient sat and the dressing change completed was close to the dirty, stained floor with several pets sitting nearby. During the observation of the dressing change, the registered nurse failed to adhere to professional standards of practice while changing the dressing when, while wearing gloves and after removing a soiled dressing, disposed of it and using the same soiled gloves reached into the supply box to search for gauze and dressing supplies. After removing the clean gauze from the box, s/he removed the soiled gloves, and without</p>	G 121	<p>See Attached</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jeanne McLaughlin* TITLE: *President/CEO* (X6) DATE: *5/12/11*

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 121	<p>Continued From page 1</p> <p>sanitizing or washing his/her hands, reached into the same supply box to retrieve a tape measure to measure the wounds. During the measurement process the tape measure touched the patients left lower leg and one of the ulcers before it was placed back into the supply box.. In addition, during the time the nurse was measuring the ulcers, a cord from his/her shirt dangled over the wound and touched one of the ulcers.</p> <p>Per telephone interview with the nurse on 4/20/11 at 9:10 AM this surveyor reviewed the written documentation of the observation of the dressing change with him/her, when s/he confirmed that a barrier had not been used during the dressing change and that the house was 'always dirty and cluttered' and although s/he hadn't thought of using a barrier it was probably a 'good idea.' In addition, when reviewing the observation with the nurse s/he commented several times 'I don't know' and 'I don't remember that.' However, s/he did confirm that touching clean dressing supplies with soiled gloves and not sanitizing his/hands was an 'infection control issue.'</p> <p>2.. Per observation on 4/19/11 at 8:45 AM of a clean dressing change to Client # 2's chronic stage IV pressure ulcer, the registered nurse failed to adhere to professional standards of practice for the dressing change. As stated in the Agency's Policy "Infection Control-Preparation of Work Area and Bag Technique; As homes differ greatly , clinical staff will need to use judgement in selecting an appropriate work area". Per observation of the dressing change, the registered nurse placed the open gauze packet directly on the bed as a clean field on which he/she laid the gauze ribbon to be used to pack Client #2's wound. During the course of the</p>	G 121	<p><i>See attached</i></p>		

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G 121	Continued From page 2 dressing change, the nurse took off her glove, dropped it on top of the clean field, potentially contaminating the area, then re-picked it up and threw it away. The nurse then laid the plastic top of a container on the field. The cap inched down to touch the gauze ribbon, potentially contaminating the area. In addition, the nurse failed to wash or sanitize her hands between changing his/her gloves. Per interview on 4/19/11, the registered nurse confirmed the above observations. 3. Per observation of a dressing change for Client #3 on 4/19/11 at approximately 1:00 PM, the nurse failed to wash or sanitize his/her hands between glove changes. Per interview at 2:30 PM that same day, the nurse confirmed that the Agency's Policy "Infection Control-Hand Hygiene" states "Decontaminate hands after removing gloves and or glove changes or whenever gloves are contaminated, punctured or torn during use".	G 121	<i>See attached</i>		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on record review and interviews the	G 236			

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G 236	<p>Continued From page 3</p> <p>agency failed to have current and /or accurate clinical records for 3 of 15 applicable patients in the sample. (Patients #4, 5 & 6) Findings include:</p> <ol style="list-style-type: none"> 1. Per record review on 04/19/11 patient #5's electronic chart showed that a family member was the person responsible for medical decisions. The chart's profile sheet indicated that patient #5 had an Advanced Directive, however no documentation was found. In addition, the visit note of 03/09/11 stated that the staff nurse made a supervision visit for LNA [licensed nursing assistant] services, however at that time the patient was not receiving nor had a care plan for LNA services. Per interview on 04/20/11 at 2:15 PM the Vice-President of Clinical Operations confirmed there was no evidence of the Advanced Directive in the record and the information for the LNA supervision visit was inaccurate. 2. Per interview during the patient's home visit on 04/19/11 at 10:00 AM, patient #6 stated that a family member is "the durable power of attorney for my health decision but [s/he] has a copy somewhere". This patient also stated that the Agency did not ask for a copy during the admission process. Per record review there was no evidence in the electronic nor hard copy of the Advanced Directive nor a Living Will. Per interview on 04/20/11 at 2:15 PM the Vice-President of Clinical Operations confirmed there was no evidence of the Advanced Directive/ Living Will in the record. 3. Per record review, Patient #4 was admitted on 3/24/11 with Physical Therapy as the primary 	G 236	<i>See attached</i>		

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G 236	Continued From page 4 skilled service. The Physical therapist who completed the admission assessment did not complete the medication list for the patient, and the original 485 Plan of Care was sent to the MD for review without the medications listed. Per interview on 4/19/11 at 2:15 PM, the Area Director and Clinical Manager confirmed that the 485 Plan of Care had been sent out to the MD without the medications listed, that the Physical Therapist had forgotten to list them, and a new updated 485 with the patient's medication list was sent to the MD.	G 236	<i>See attached</i>		

POC for 042011

ID Tag	Plan of Correction	Comp Date	Responsible Party
G121	Clinical Managers will monitor adherence to wound care technique, bag technique and hand washing during field home care nurse supervisory visits.	Begin May 1, 2011 and ongoing	Clinical Managers
	Clinical Managers will report non compliance and address thru performance improvement plan.	Begin May 1, 2011 and ongoing	Clinical Managers
	Clinical Managers performed a supervision visit to observe dressing change for the 3 nurses mentioned in the deficiencies.	Completed May 10, 2011	Clinical Managers
	Clinical Managers will conduct skill competencies for all field home care nurses on proper dressing change technique, hand washing and bag technique.	Complete May 24, 2011	Clinical Managers
	All nursing staff will receive education regarding current wound care practice.	Complete May 24, 2011	Clinical Managers
G 236	Director of Quality Improvement is responsible for monthly audits which includes review of the presence or attempt to obtain advance directives/durable power of attorney for healthcare when indicated	Begin May 1, 2011 and ongoing	Director of Quality Improvement
	Director of Quality Improvement will report compliance of advance directives/durable power of attorney in medical record on a biannual basis to the Quality Council.	Begin May 1, 2011 and ongoing	Director of Quality Improvement
	VP of Clinical Services will provide reeducation of admission staff regarding need to request and/or document failure to obtain advance directives/durable power of attorney during admission process.	24-May-11	VP of Clinical Services
	Director of Quality Improvement is responsible for chart audits to check for accuracy of documentation including accurate medication profile and supervision of aides.	Begin May 1, 2011 and ongoing	Director of Quality Improvement
	Director of Quality Improvement will report compliance of documentation accuracy including medication profiles and aide supervision on a biannual basis to the Quality Council.	May 2011 and ongoing	Director of Quality Improvement
	Clinical Managers will re-educate field staff regarding need to check for both orders and beginning of visits to ensure appropriate HHA supervision is completed.	Complete May 24, 2011	Clinical Managers
	Rehabilitation Director will re-educate therapy staff regarding need to complete medication profile on admission for transfer to physician plan of care.	Complete May 24, 2011	Rehabilitation Director

POC amnt 5-18-11 DCH/S

POC amnt 5.18.11 DCH/S