

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

PRINTED: 04/02/2010
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
APR 15 2010

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 C 03/12/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VNA & HOSPICE OF VERMONT AND NH	STREET ADDRESS, CITY, STATE, ZIP CODE 1 HOSPITAL COURT BELLOWS FALLS, VT 05101
--	--

(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
L 000	INITIAL COMMENTS	L 000		
L 523	<p>An unannounced on-site investigation was conducted on 2/17/10 and completed on 3/12/10 by the Division of Licensing and Protection.</p> <p>418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the interdisciplinary group failed to meet within 5 calendar day after the election of hospice for 1 applicable client. (Client #4) findings include:</p> <p>1. Per record review, there is no evidence that the RN consulted with other interdisciplinary group (IDG) members to develop a plan of care after the initial assessment on 11/18/09. Client #4 had a start of care date of 11/18/09 and the first interdisciplinary group (IDG) meeting was noted on 12/15/09. On 3/5/10 at 12:30 PM the Hospice Director confirmed the initial IDG meeting was missed.</p>	L 523	<p>Action to Correct:</p> <p>Create two e-mail accounts (north and south) to include five members of interdisciplinary team (IDT) and Hospice Director by end of week 4/16/10</p> <p>On day of admission, nurse will send e-mail to appropriate north or south team, to consult with other IDT team members about Plan of Care (POC) creation beginning week of 4/26/10. Each member of the team will document in the case conference category under "note" type admission summary within 5 days of admission.</p> <p>Educate staff of new process by 4/30/10.</p> <p>Measurement:</p> <p>Hospice Director will run an admissions status report daily to be sure all newly-admitted patients have had an e-mail created. Hospice Director will track return of admission summary notes beginning week of 4/12/10.</p> <p>Monthly Hospice Director will report percentage of month's admissions that were compliant with team response in admission notes beginning with month of May, 2010.</p> <p>VP Performance Improvement will report data to PAQC.</p>	
L 555	<p>418.56(e)(2) 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>(2) Ensure that the care and services are provided in accordance with the plan of care.</p>	L555	<p>Action to Correct:</p> <p>Education to schedulers, clinicians, intake that if order is a finite date, visit type will be Coded as "Plus Routine Visit." This visit cannot be changed to another date.</p> <p>E-mail education to all staff week of April 12, 2010.</p>	

See attached
4/22/10
Susan Linnon PA
accepted
POC with admissions

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeanne M. Loughlin</i> 4/12/10	(X6) DATE
--	-----------

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: 04/02/2010
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 C 03/12/2010
NAME OF PROVIDER OR SUPPLIER VNA & HOSPICE OF VERMONT AND NH			STREET ADDRESS, CITY, STATE, ZIP CODE 1 HOSPITAL COURT BELLOWS FALLS, VT 05101		
(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	
L 555	Continued From page 1 This STANDARD is not met as evidenced by: The Hospice failed to provide care and services in accordance with the care plan for 1 applicable client. (Client #9) Findings include: 1. Per record review on 2/17/10 nursing failed to provide wound dressing changes as ordered. On 2/18/10 a physician's order was for wound dressing changes every 5-7 days. No wound assessment or changes were made for 8 days from 02/23/10 -03/03/10. The Hospice Directed confirmed the above on 03/05/10 at 12:30 PM.	L 555	Follow-up education again at team conferences by May 14, 2010. <u>Measurement:</u> Monthly audit of at least 60 homecare records to ascertain compliance with MD orders beginning May 2010. Report out compliance with orders at PAQC.		
L 594	418.64(c) MEDICAL SOCIAL SERVICES Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services. This STANDARD is not met as evidenced by: Based on record review and interview the Agency failed to provide social workers' services for 1 applicable client. (Client #4) Findings include: 1. Per record review a physicians's order dated 1/18/10 direct the social worker (MSW) for a visit once a month and 1 as needed (PRN). The MSW did not contact the client until 3/5/10 as noted in the record, missing the January visit. The Hospice Director confirmed this on 3/5/10 at 12:30 PM.	L 594	<u>Action to Correct:</u> Re-educate MSW staff regarding order generation via e-mail and at staff meeting prior to May 14, 2010. Schedulers will double check every AM for ungeneratetd orders effective 4/12/10. Schedulers will schedule MSW visits by April 30, 2010. <u>Measurement:</u> In conjunction with L523, 100% of hospice admissions will be reviewed by Hospice Director to be sure MSW discipline admission order in system. Percentage of patients compliant with MSW evaluation 5-day order will be reported monthly to VP of Performance Improvement by Hospice Director beginning May, 2010.	See ADDENDUM attached accepted POC 4/22/10 See ADDENDUM attached accepted POC 4/22/10	

VNA of VT/NH
complaint survey 3/12/10

ADDENDUMS

L-523 - Per telephone conversation with Jeanne McLaughlin, CEO and Steven Mooney, Hospice Director on 4/22/10 at 3:00 P.M. the Plan of Correction for L523 is accepted with the following addendum:
The ~~Hos. Dir.~~ ^{Hosp. Dir.} is responsible to assure the Action to Correct interventions will be in compliance with Federal Regulations with a completion date of 4/30/10.

L-555 - Per telephone conversation with Jeanne McLaughlin, CEO and Steven Mooney, Hospice Director on 4/22/10 at 3:00 P.M. the Plan of Correction for L555 is accepted with the following addendum:
The Hospice Director is responsible to assure the Action to Correct interventions will be in compliance with Federal Regulations with a completion date of 4/12/10.

L-594 - Per telephone conversation with Jeanne McLaughlin, CEO and Steven Mooney, Hospice Director on 4/22/10 at 3:00 P.M. the Plan of Correction for L594 is accepted with the following addendum:
The Hospice Director is responsible to assure the Action to Correct interventions will be in compliance with Federal Regulations with a completion date of 4/12/10.

Accepted
POC'S
4/22/10
Susan J. Emmons, RN