

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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Voice/TTY (802) 871-3317
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October 9, 2012

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 Federal Home Health recertification survey conducted on **August 29, 2012**.

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

SEP 12 12

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2012
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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
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G 000	INITIAL COMMENTS An unannounced Federal Home Health recertification survey was conducted by the Division of Licensing & Protection between the dates of 8/27/12 and 8/29/12. The following regulatory violations are related to the Federal survey.	G 000		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency staff nurse failed to coordinate services and to inform the physician of changes in dressing change frequency and/or a missed nursing visit for 2 of 20 patients in the sample. (Patient # 1 and #2) Findings include: 1. Per record review on 08/28/12 Patient #1 was admitted on 03/24/12 for rehab services and ulcer to the left thumb which required per the physician's orders a dressing change every other day using peroxide and Mepilex. Per review of the visit notes for therapy on 03/24/12 there was no assessment for the ulcer. Per the therapy note of 03/26/12 states "wound from wearing splint pink/red 1.8 cm, patient states dressing changed every 3 days -call to nursing for wound management". Per nursing note of the 03/27/12 visit states patient fell and broke his wrist has Mepilex on for 7 days'. There are no communication notes to the physician regarding	G 176	POC accepted 10/9/12 D. Chelender, Franonka, and NLS	08/17/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeannie DeFurghlin</i>	TITLE President/CEO	(X6) DATE Spot 17, 2012
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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 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 176	Continued From page 1 the discrepancies of the dressing changes. Per interview on 08/29/12 at 1:30 PM the Performance Improvement Coordinator confirmed that therapy and/or nursing did not inform the physician of dressing changes or discrepancies. 2. Per record review on 08/29/12 the staff nurse failed to notify the physician of the missed and/or canceled visits for Patient #2 during the month of March/April 2012. Per interview on 08/29/12 at 2:45 PM the Maternal Child Manager stated that the orders that the staff nurse wrote on 03/12/12 for visits were "confusing" and "at best the nurse should've wrote a FYI order for the missed visits or had a wider range of the actual visit to be made". S/he confirmed that the staff nurse did not inform the physician of the canceled or missed visits.	G 176			
G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by: Based on record review and staff interview the Admission OASIS data did not accurately reflect the status at the time of assessment for 1 applicable patient. (Patient #1) findings include: 1. Per record review on 08/27/12 of Patient #1's electronic chart, the admission OASIS did not reflect accurate information regarding the a wound Per the referral note of 03/22/12, Patient #1 had a fracture to the left wrist in which the splint caused a ulcer to the left thumb and also had a healed incision to the left hip. In addition	G 322			

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G 322	Continued From page 2 the referral note and physician order stated " assessment of left thumb ulcer and dressing change every other day. Per the admission OASIS on 03/24/12 the therapy failed to identify the wound on the left thumb. Per interview on 08/29/12 at 2:00 PM the Performance Improvement Coordinator confirmed that the OASIS data did not accurately reflect the patient's status.	G 322		
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on record review and interviews with agency staff, the agency failed to make the initial assessment visit within 48 hours of the referral date for 2 of 20 patients in the sample. (# 4 and # 3). Findings include: 1. Per record review begun on 08/27/2012 and completed on 08/29/2012, Patient # 3 was referred to the agency for services on 04/26/2012. There was an anticipated discharge date documented as 04/27/2012 with a start of care (SOC) date listed to be 04/28/2012. The 04/28/2012 date is found to be crossed off and changed to 04/30/2012. The SOC is 04/30/2012 despite the fact that the patient/ family telephoned the agency on 04/28/2012 with concerns about his/her condition. 2. Per review on 08/28/12, Patient #4 was admitted on 08/20/12. Per review of the the referral dated 08/16/12 and Hospital discharge	G 332		

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G 332	Continued From page 3 papers, the physician wrote that the patient was being discharged home on the 17th of August. and was to be seen by the Agency. There was no documentation that the patient was contacted prior to August 20th or whether the patient requested a visit after 48 hours of coming home. In addition, there was no evidence that the physician was notified that the admit date would be 3 days later. During an interview with the V-P of Operations on 08/29/2012 at 2:00 PM s/he confirmed that there is no documented evidence to support a SOC date beyond the 48 hour expected time-frame from referral to initial assessment visit.	G 332			

Survey Date 08/29/12

ID Tag	Plan of Correction	Comp Date	Monitored by
G176	Professional staff will complete a Care2Learn module regarding documentation requirements regarding orders and informing physician of changes in condition.	Begin September 24, 2012. To be completed by October 31, 2012	Director Performance Improvement
	Clinical management to continue with joint staff visits to review skills/competencies with increased emphasis on assessment and necessity of notifying physician with any clinical changes.	Current and ongoing	VP of Clinical Services with Director of Rehab and Clinical Managers
	90 day audit of 30% of SOC home care admissions with wounds to be sure services provided match those ordered by physician.	September 17, 2012 thru December 14, 2012	Director Performance Improvement
	90 day audit of 30% of MCH admissions to be sure services provided match those ordered by physician.	September 17, 2012 thru December 14, 2012	MCH Clinical Manager
G322	Professional staff will attend an in-service by nationally recognized OASIS expert focusing on accurate assessment strategies and documentation of OASIS data.	November 6-8, 2012	VP of Clinical Services with Director of Rehab and Clinical Managers
	Add an additional educator to agency staff who will assist clinical management with joint visits to assess OASIS competency and accuracy.	Begin September 10, 2012	Director of Performance Improvement

Monthly audit of 10% of Therapy start of care OASIS for 90 day, beginning 9/17/12, to assure orders and service match those ordered by the physician.

September 17, 2012 Director of Rehab thru December 14, 2012

G332

Review of all weekend therapy referrals on Monday AM to determine admission status and to be sure all communication with patient and physician documented in record.

Begin September 4, Director of Rehab 2012

90 day audit of 30% of weekend therapy admissions to ensure assessment visit within 48 hours or requested with case note if request for later than 48 hours post referral with interim order to physician notifying of change.

Beginning Director of Rehab September 24, 2012 and ongoing