

Division of Licensing and Protection
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To Report Adult Abuse: (800) 564-1612
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February 11, 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 Federal survey conducted on **December 28, 2010**.

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
FFR 0 7 11

PRINTED: 01/07/2011
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 _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED R 12/28/2010
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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	{G 000}		
{G 176}	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews agency staff failed to document that the physician and/or nursing supervisor was notified immediately after one patient (Patient # 1) verbalized suicidal ideations as well as a suicide plan. Findings include:</p> <p>On 12/22/10 a record review was conducted for Patient # 1 who reported to the nurse making the 10/21/10 home visit that s/he would 'end their life' if they were unable to get the 'drugs they needed from their physician to relieve their pain' and verbalized a plan on how they would do so. During a review of the clinical notes for 10/21/10 there is no documentation by the nurse that s/he notified the physician or the supervisor of the patient's threats until the next day. (on 10/22/10) Per interview on 12/21/10 at 2:32 PM with the agency nurse that made the 10/21/10 visit s/he confirmed that they had not documented that the physician, psychiatrist or nursing supervisor were</p>	{G 176}	See attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chula Austin for Jeanne McLaughlin CEO</i>	TITLE <i>CEO</i>	(X6) DATE <i>1/19/11</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 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 notified after the patient had made a suicide threat and that they did not report the threat until the next day, 10/22/10. Per interview with the VP of Clinical Services on 12/28/10 s/he confirmed, after reviewing the clinical documentation, that there was no evidence that the nurse had contacted the physician or supervisor until the day after the threat was made. In addition, s/he confirmed that although agency staff had access to a 'Suicide Prevention Risk Assessment' policy manual (by the VNA's of America) the agency did not have a written policy & procedure to direct staff after a patient makes a suicide threat, and that they relied on their 'professional judgement.'	{G 176}	<i>See attachal</i>	

ID Tag	Plan of Correction	Completion Date	Person Responsible
G176	<p>We respectfully disagree that Patient #1 was at risk for an "immediate" suicide attempt. The patient's statement, as recorded in the chart notes for 10/21/10, was that if s/he could not get the pain medication s/he wanted at the next doctor's visit, s/he would take action. The "threat" was contingent on future events and the nurse appropriately intervened before those events occurred. Further, the nurse was aware that both the patient's primary care physician (whom s/he would be seeing the next day) and her/his psychiatrist were aware of the patient's contingent threat as documented in the note of 10/21/10. Also, Patient #1 refused to allow the nurse to use the phone to call her/his primary care physician while in the home as documented in the note of 10/21/10. Patient #1's spouse was included in this discussion, as s/he is a nurse; and patient #1 was not left unsupervised.</p> <p>The nurse called the primary care physician early the next morning and secured the referral and immediate attention of a suicide prevention specialist as documented in the note of 10/22/10. The nurse also followed up with the primary care physician's office later in the day to make sure the particular physician seeing Patient #1 knew of the contingent threat and was informed that Patient #1 would be evaluated by a crisis team (notes of 10/22/10).</p> <p>The steps taken by the nurse are in compliance with the VNAA guidelines that are used by hundreds of VNAA's around the country. The Agency also notes that the nurse's actions met the requirements of 484.30(a) in that the clinical and progress notes were completed and the physician was informed of changes in the patient's condition and needs. There are no "immediate" requirements in this standard, and documentation by the nurse was timely.</p>		
	Communication with field staff to re-enforce use of VNAA guidelines. Staff will be directed to call the office to speak with a clinical manager with any indication of suicide ideation and/or plans.	January 25, 2011 and ongoing	VP of Clinical Services
	Clinical managers will review documentation to ensure proper notice and documentation is completed and report/correct any inconsistencies to the VP of Clinical Services	January 25, 2011	VP of Clinical Services
	Education to clinicians of need to complete an incident report whenever a suicide risk is identified.	February 14, 2011	VP of Clinical Services
	VP Performance Improvement will review all incident reports to insure VNAA suicide guidelines are addressed in clinical notes.	Beginning February 2011	VP for Performance Improvement

E176 POC Accepted 2/10/11 D Chittenden RN / P M Coletta RN