VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
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Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
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January 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 **December 16, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	VT477002		C 12/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNA OF VT & NH	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) COMPLETE DATE
H 001	Initial Comments An unannounced on-site complaint investigation for the Designation and Operation of Home Health Agencies was conducted by the Division of Licensing and Protection from 12/07/10 and completed on 12/16/10. There were regulatory violations.	H 001	See attached Received 1.19.11	
H1425 SS=D	14.5 Clinical Records XIV. Clinical Records 14.5 The clinical note shall be written and incorporated into the patient's clinical record within a timeframe that will ensure that the patient ' s status is communicated to other caregivers and in accordance with the home health agency's policies and procedures. The clinical note shall include, but not be limited to a written description of signs and symptoms, treatment and medications administered; and the patient's response and any changes in physical or mental status. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews clinical notes were not incorporated into the patient's medical record in a timely manner to ensure patient status was communicated to other caregivers for 2 applicable patients (Patient's 1& 2) Findings include: 1. Per record review on 12/07/10, Patient #2's medical record did not contain a visit note for a 10/29/10 visit. Per interview on 12/07/10 at 3:53 PM, the staff nurse stated that the patient was not homebound and had no other private insurance for this admission. S/he confirmed that the	H1425		

Joanne McLaughlin President/CEO 1/12/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Division of Licensing and Protection

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H1425	Continued From page 1 medical record did not contain a note explaining the status of that visit. A late entry note was entered on 12/09/10, more than 1 month after the visit on 10/29/10 and 2 days after the nurse surveyor's review. 2. Per record review conducted on 12/7/10, nursing Case Communication Notes for the date of 8/8/10 documented that 3 telephone calls were placed to the on-call Supervisor at 7:10 PM, 7:40 PM and 9:40 PM by Patient # 1's wife to report problems with flushing her husband's central line (PICC line) Resident #1's wife requested that a 'visit be made that evening by the on-call visit nurse to assess the PICC line.' The supervisor documented that several phone calls were made to the nurse on-call informing them that s/he needed to make a 'home visit that evening to assess the patient's PICC line.' Further review of the record showed no further documentation by the supervisor or the on-call nurse that a visit or a telephone call had been made to the patient's home that evening to address the status of the PICC line. On 12/7/10 at 2:45 PM the VP of Clinical Services, after reviewing the clinical notes, confirmed there was no documentation that the patient had received either a phone call or a nursing visit that evening and in addition, 'the staff nurse on call that evening is no longer employed at the agency.'	H1425	See attached Doc amend 1.15.11 Sam 28	
H1715 SS=D	17.14 Patient Rights XVII. Patient Rights 17.14 A patient has the right to appeal a notice of reduction or discontinuation of home health agency services or a denial of admission to the	H1715		

Division of Licensing and Protection

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H1715	Continued From page 2 home health agency and to receive information about the appeal process This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home health agency failed to assure 1 applicable patient was provided the information about the appeal process. (Patient #2) Findings include: 1. Per record review on 12/07/10, Patient #2's medical record did not contain documentation that the patient received information regarding the appeals process for an admission on 10/29/10. Per interview on 12/07/10 at 3:53 PM, the staff nurse stated that the patient was not homebound and had no other insurance. The nurse further confirmed that the appeals notice was not given to the patient nor information on other payment options for providing services. A late entry note in the medical chart dated 12/09/10 states "patient not admitted to service, states has medicare and not homebound ....called MD asked about other insurance, talked to nurse to let her know..." Per telephone interview on 12/16/10 at 4:11 PM, Patient #2 confirmed that the nurse did not explain or give any information regarding patient's rights about the appeals process for admission and in fact is receiving services from another Agency.	H1715	See attached Re-cert 1.19.11 Susan [illegible]	

ID Tag	Plan of Correction	Comp Date	Responsible Party
H1425	Corrective action has been ongoing since November 30th - see response to G 176 from October 25, 2010 survey. Note the agency is in substantial compliance as found on December 17, 2010. See Attachment A		
	The VP of Finance will add the completion of the visit to the audit tool to ensure compliance with timeliness	Beginning 1/17/11	VP Finance
	VP of Clinical Services will be responsible for reporting individual compliance rate for timely documentation. The data will be reported to the Quality Council quarterly.	Beginning February 2011 and ongoing	VP Clinical Services
H1715	Patient #2 was not admitted on 10/29/10; rather an evaluation visit was begun which resulted in a finding that the patient did not meet the requirements for Medicare coverage of an episode for home care. The MD was contacted and a plan was made for the patient to receive care at the MD office. The patient and MD were both in agreement with this plan which resulted in withdrawal of request for admission.		
	Clinical Managers will mail a copy of the Notice of Change to all non-admitted/cancelled admissions.	January 25,1011	Clinical Managers
	Clinical Managers will document that the Notice of Change (non admission) was mailed in the notes section of the record	January 25,1011	Clinical Managers
	VP of Clinical Services will be responsible for audit of all not admitted patient's records. Records will audited monthly for 3 months to ensure documentation of mailed form is present.	Beginning February 1, 1011	VP Clinical Services

PLAN OF CORRECTION
VISITING NURSE ASSOCIATION HOSPICE OF VT NH

	Agency hired additional social worker in September 2010 who finished orientation in October 2010.	11/30/10	Director of Hospice
	Director of Hospice will report number of days from order to visit/contact by MSW each month to Director of PI.	11/30/10	Director of Hospice in conjunction with Triage Manager and Director of PI
	Director of Hospice will provide monthly reports to Director of PI regarding MSW timeliness.	11/30/10	Director of Hospice in conjunction with Triage Manager
H 1425	Agency policy is that all visit documentation will be incorporated into the record by midnight of the day the service is provided. This policy will be reinforced to all field staff during the next all-agency meeting by the Senior Leadership team.	12/7/2010	Clinical Management
	Chart audit to include review of documentation for physician contact when unable to perform ordered procedures.	11/30/2010 and ongoing	Quality Coordinator
	Results of chart audits will be reported to the quality council on a biannual basis.	11/30/10	Quality Coordinator
H 1707	Please see responses H 625, 649 and 824.		
H 1806	Please see responses H 511, 649, 824 and 1707.		
H 1812	The cause of the missed dose has not been determined. An analysis of the event is inconclusive.		
	The contracted nurse has had a supervisory visit done by clinical management to evaluate her infusion therapy skills.	11/15/2010	Clinical Management

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

PRINTED: 12/28/2010
FORM APPROVED
OMB NO. 0938-0391

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G 000	INITIAL COMMENTS An unannounced complaint investigation was conducted by The Division of Licensing and Protection from 12/07/10 and was completed on 12/16/10. Based on the Federal Home Health Rules and Regulations, the following regulatory violations are noted:	G 000		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to assure that the clinical record for 2 of 4 patients in the targeted sample reflected changes in coordination of care and/or communication with the client. (Patients #1 & #3) Findings include: 1. Per record review on 12/07/10 Patient #3's clinical record did not have information regarding the patient's telephone complaints to the Agency. Review of the case communication notes from 04/14/10 through 07/07/10 had no documentation from the patient nor the case manager. A Case Manager note dated 07/07/10 states " [patient] said since no one was returning [phone] calls and that s/he needed help with forms will change Case Manager to COA (Council on Aging)". Per interview on 12/7/10 at 3:35 PM, the Long Term Coordinator confirmed no communication regarding the complaints from the patient were reported to staff members and no coordination	G 144	See attached Pl. Carol 1-25-11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon J. McLaughlin | TITLE: President/CEO | (X6) DATE: 1/12/11

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 144	Continued From page 1 with the patient happened for a 3 month period.. 2. Per record review on 12/7/10 of the nursing documentation for the date 8/6/10, the nurse was unable to draw enough blood from a PICC line for Patient # 1's labwork and drew the blood from a venipuncture to the right hand. There was no documentation in the clinical record that the physician was notified by the nurse that he/she was unable to draw blood through the PICC line for the labwork. This was confirmed on 12/7/10 at 2:45 PM by the VP of Clinical Services.	G 144	See attached Received 1.14.11	
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 reviews and staff interviews, the agency failed to ensure the clinical records for 2 of 4 applicable patients contained pertinent past and current findings that facilitated effective, efficient & coordinated care. (Patients #1 & 2) Findings include: 1. Per record review conducted on 12/7/10, nursing Case Communication Notes for the date of 8/8/10 documented that 3 telephone calls were	G 236		

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G 236	Continued From page 2 placed to the on-call Supervisor at 7:10 PM, 7:40 PM and 9:40 PM by Patient # 1's wife to report problems with flushing her husband's central line (PICC line). Resident #1's wife requested that a 'visit be made that evening by the on-call visit nurse to assess the PICC line.' The supervisor documented that several phone calls were made to the nurse on-call informing them that s/he needed to make a 'home visit that evening to assess the patient's PICC line.' Further review of the clinical record showed no other documentation by the supervisor or the on-call nurse that a visit or a telephone call had been made to the patient's home that evening to assess the status of the PICC line. On 12/7/10 at 2:45 PM the VP of Clinical Services, after reviewing the documentation, confirmed there was no documentation that the patient had received either a phone call or a nursing visit that evening and stated that 'the staff nurse on call that evening is no longer employed at the agency.' 2. Per record review on 12/07/10 at 9:30 AM, Patient #2's medical record contained incorrect information regarding admission. Per the admission record of 10/08/10, the profile tab listed 'Hospitalized' as the reason for not being admitted to the Agency. Per the visit note of 10/08/10 stated "doctor's office called and said to send to ER'. Per interview on 12/01/10 at 3:53 PM the nurse stated that 'I assumed the patient was being admitted'. S/h confirmed that the patient was not admitted to the hospital and the admission record contained incorrect information.	G 236	See attached Rec'd 1.25.11	

ID Tag	Plan of Correction	Comp Date	Responsible Party
G144	During the exit interview, the Agency was told that there were no findings related to Patient 3. Patient 3 was a self-directed care patient. The Agency does not have any record of Patient 3 calling for help or with a complaint. The case manager note of 7/7/10 quoted the patient as having said she was not receiving return phone calls, but id does not say that it was the Agency who did not return calls. The case manager involved was terminated by the Agency for performance related reasons, and additional supervision of case managers has been implemented by the Agency by a new director of Long Term Care has been added since July 2010. With this factual introduction and framework, the plan of correction follows.		
	Director of LTC is responsible for monthly audit of all highest needs patients to ensure contact has occurred during the calendar month.	January 25, 2011 and ongoing	Director of Long Term Care
	Director of LTC will report compliance regarding monthly contact. Results will be reported quarterly to the Quality Council.	February 2011 and ongoing	Director of Long Term Care
	Regarding patient #1, Clinical Managers will remind staff that they must document notification of physician whenever they are unable to draw blood from a PICC line.	January 11, 2011 and ongoing	Clinical Managers
	Corrective action has been ongoing since November 30th · see response to G 176 from October 25, 2010 survey. Note the agency is in substantial compliance as found on December 17,2010. See Attachment A		
G236	Nurse called patient to let them know time of visit. Patient/family declined visit due to lateness of hour. Agency policy is that all documentation be incorporated into the medical record by midnight of the date services were provided. This policy was reviewed at the December 2010 all agency Meeting.		
	The individuals "scrubbing" the visit documentation audit the date visit documentation completed	January 17, 2011 and ongoing	VP Finance
	Individual compliance rate for timely documentation will be reported to the Quality Council quarterly.	February 1, 2011 and ongoing	VP Clinical Services
	The agency use of hospitalization includes being sent to ED. Patient #2 was not admitted on 10/8/10 rather an evaluation visit was begun which resulted in a finding that per the physician - status of patient wound required patient to be sent to the hospital.		
	Add reason "patient sent to ED" to drop box for patient not being admitted in the horizon system.	January 17, 2011 and ongoing	Information Systems Manager

	Random audit of at least 30 home care skilled wound care patients charts by Clinical Managers to assure complete documentation according to physician orders of wound care that was provided during home visit will be conducted. Results to be reported to Director of PI.	12/17/2010	Clinical Management with Director of PI
	Clinical managers to re-emphasize to staff the necessity to document all attempts to contact patients to establish care.	11/8/10	Clinical Management
	Random audit of at least 30 home care patients charts to review adherence to physician orders regarding visit frequency will be conducted by Clinical Managers. Quality Coordinator will report results to Quality Council.	11/30/10	Clinical Director/Quality Council
G 168	See G121, G174 and G176. The Agency disputes that the issues cited rise to the level of conditional violations.		
G 174	See G 121		
G 176	Agency policy is that all visit documentation will be incorporated into the record by midnight of the day the service is provided. This policy will be reinforced to all field staff during the next all-agency meeting by the Senior Leadership team.	12/7/2010	Clinical Management
	Chart audit to include review of documentation for physician contact when unable to perform ordered procedures.	11/30/2010 and ongoing	Quality Coordinator
	Results of chart audits will be reported to the quality council on a biannual basis.	11/30/10	Quality Coordinator
G 195	Social work orders will be reviewed on each business day to ensure appropriate MSW scheduling.	11/30/10	Director of Hospice (MSW reports to Hospice Director) in conjunction with Triage Manager
	Agency hired additional social worker in September 2010 who finished orientation in October 2010.	11/30/10	Director of Hospice
	Director of Hospice will report number of days from order to visit/contact by MSW each month to Director of PI.	11/30/10	Director of Hospice in conjunction with Triage Manager and Director of PI
	Director of Hospice will provide monthly reports to Director of PI regarding MSW timeliness.	11/30/10	Director of Hospice in conjunction with Triage Manager
G 214	HR will provide a monthly report to all management indicating upcoming evaluations due in the next quarter. Clinical management is expected to complete performance evaluations timely.	12/15/2010	Director of HR and clinical management team
	Director of HR will track outstanding LNA performance evaluations monthly	12/15/2010	Director of HR
	Director of HR will trend and present data regarding overdue LNA evaluations to quality counsel.	12/15/2010	Director of HR and clinical management team