VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
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Survey and Certification Reporting Line:(888) 700-5330
To Report Adult Abuse: (800) 564-1612

September 7, 2023

Ms. Lyne Limoges, Administrator
Orleans Essex VNA & Hospice
46 Lakemont Road
Newport, VT 05855

Provider ID #: 477018

Dear Ms. Limoges:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **July 19, 2023**.

Follow up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Division Director

Enclosure

PRINTED: 08/02/2023
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477018	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orleans Essex VNA & Hospice	46 Lakemont Road , Newport, Vermont, 05855

(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
E0000	Initial Comments An unannounced onsite Survey was conducted on 07/17/23 through 07/19/23 by the Division of Licensing and Protection to determine compliance with Condition of Participation for Home Health Agencies (HHAs) Emergency Preparedness Program Code of Federal Regulations (CFR) at §484.102. The following regulatory violations were identified:	E0000		
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 484.102(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment,	E0006	**E0006 Plan Based on All Hazards Assessment** **CFR(s): 484.102(a)(1)-(2)** The Jr/Sr. Management group that consists of the Executive Director, Human Resource and Finance Directors, and the Managers of Nursing, Rehab and Long Term Care met on 8/10/2023 at 8am to review/update the current Emergency Plan (EP) based on the all All Hazards Risk Assessment. The updated EP will be presented to the Board of Directors at the August meeting on 8/28/2023 for their approval. **Tag E0006 POC accepted on 9/7/23 by S. Freeman/P. Cota**	

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E0006	Continued from page 1 utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on review of Orleans/Essex Visiting Nurse Agency's Emergency Preparedness Program, the facility failed to review and update their plan and facility/community risk- based assessment as required at least every two years and upon such changes train/educate staff accordingly and document dates of EP reviews. Findings include: Review of the agencies Emergency Preparedness (EP) program revealed outdated information, plans and policies located in a binder dating back to 2017 and 2018. A memorandum "RE: HFQC manual Revision to Section 9 Emergency Preparedness" was provided to reflect that	E0006		

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E0006	Continued from page 2 such reviews had occurred in "November 2017" and staff had received training and handouts regarding these changes, however this dates back six years. Interview on 07/18/23 at 10:30am with the Executive Director confirmed that the Emergency Preparedness Program has not been reviewed due to the pandemic, a ransom ware attack and timing. The agency had a discussion previously related to the need for review but had not been documented and will now work on this.	E0006		
E0013	Development of EP Policies and Procedures CFR(s): 484.102(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power,	E0013	**E0013 Development of EP Policies and Procedures** **CFR(s): 484.102(b)** The Jr/Sr. Management group that consists of the Executive Director, Human Resource and Finance Directors, and the Managers of Nursing, Rehab and Long Term Care met on 8/10/2023 at 8am to review/update the Agency's Emergency Plan and Community Based Risk Assessment. The Emergency Preparedness Plan will be updated to include all updated components and will be distributed to staff with education/training for all staff once approved by the Board of Directors at the August 28, 2023, Board of Directors meeting. The EP will be reviewed/updated and scheduled for review during their August Board of Director Meetings annually. **Tag E0013 POC accepted on 9/7/23 by S. Freeman/P. Cota**	

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E0013	Continued from page 3 or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is NOT MET as evidenced by: Based on review of Orleans/Essex Visiting Nurse Agency's Emergency Preparedness (EP) Program, the facility failed to review and update EP Policies and Procedures to align with the identified hazards within the agencies risk assessment at least every 2 years and upon such changes, train/educate staff accordingly and document dates of the EP policy and procedure reviews and updates. Findings include: Review of the agencies Emergency Preparedness (EP) program and EP policies and procedures revealed outdated information, plans and policies located in a binder dating back to 2017 and 2018. A memorandum "RE: HFQC manual Revision to Section 9 Emergency Preparedness" was provided to reflect that such reviews had occurred in "November 2017" and staff had received training and handouts regarding these changes, however this dates back six years. Interview on 07/18/23 at 10:30am with the Executive Director confirmed that Policies and Procedures related to Emergency Preparedness Program had not been reviewed due to the pandemic, a ransom ware attack and timing. The agency had a discussion previously related to the need for review but had not been documented and will now work on this.	E0013		
G0000	INITIAL COMMENTS	G0000		

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G0000	Continued from page 4 An unannounced onsite Federal Recertification Survey was conducted on 07/17/23 through 07/19/23 by the Division of Licensing and Protection to determine compliance with Home Health Agencies Conditions of Participation at Part 484. The following regulatory violations were identified:	G0000		
G0428	Property and person treated with respect CFR(s): 484.50(c)(1) Have his or her property and person treated with respect; This ELEMENT is NOT MET as evidenced by: Based on observation, interview, and record review the agency failed to provide a visit schedule based on patient preferences for 1 applicable Patient in the sample (Patient #1). Findings include: During observation of a home visit with an Occupational Therapist (OT) on 7/17/2023 Patient #1 asked the OT when the next visit would be. The OT informed the patient it would be next week. When the patient asked what day, the OT replied that s/he was not sure what day, but s/he would call ahead of time to let the patient know. Per record review the patient has missed several therapy appointments due to not being home or medical appointments. Review of Patient Quick Notes written on 5/11/23 visits for both nursing and aide were cancelled due to the patient having a doctor appointment. Another note written on 6/22/23 reflects that the patient canceled the OT visit because Physical Therapy (PT) was coming, and s/he did not want two therapies in one day. On 6/23/2023 the patient cancelled PT due to having several appointments. Per interview with the Executive Director (ED) on 7/19/23 at approximately 12:00 PM, patients receive a form on admission that is filled out to indicate the visit frequency and expected treatment for each discipline that includes nursing, physical therapy, occupational therapy, speech therapy, home health aide, and social work, however it does not always indicate the day or time of the specific visit. The ED confirmed that the agency does not provide patients with a schedule based on the convenience of the patient.	G0428	**G0428 Property and person treated with respect** **CFR(s): 484.50(c)(1)** The Rehab Manager met with the staff member (OT) to discuss this particular incident. Clinicians are scheduled to meet with their supervisors to discuss changes in the process to ensure patient Plan of Cares are updated at admission and assessments to include frequency of visit and patient preferences. Clinical supervisors will meet with their staff to provide forms and processes changed. Nursing staff are scheduled to meet on Tuesday 8/15/2023, and Rehab on Thursday 8/17/2023. **Tag G0428 POC accepted on 9/7/23 by S. Freeman/P. Cota**	