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
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line:(888) 700-5330
To Report Adult Abuse: (800) 564-1612

December 20, 2018

Janet McCarthy, Administrator
Franklin County Home Health & Hospice
3 Home Health Circle Suite 1
Saint Albans, VT 05478

Provider ID #:471501

Dear Ms. McCarthy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 27, 2018**.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471501	A. BUILDING ______ B. WING ______	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY HOME HEALTH & HOSPICE	3 HOME HEALTH CIRCLE SUITE 1 SAINT ALBANS, VT 05478

(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
E 000	Initial Comments At the time of the re-certification Hospice survey conducted by the Division of Licensing and Protection on 11/26/18 - 11/27/18 the Emergency Preparedness survey was conducted. The Hospice agency was found to be in Substantial Compliance with the Federal requirements for Emergency Preparedness.	E 000		
L 000	INITIAL COMMENTS An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 11/26-27/2018. The following were regulatory findings identified during the survey:	L 000	See attached.	
L 541	APPROACH TO SERVICE DELIVERY CFR(s): 418.56(a)(1)(i)-(iv) The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles: (i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice). (ii) A registered nurse. (iii) A social worker. (iv) A pastoral or other counselor. This STANDARD is not met as evidenced by: Based on medical record review for 12 out of 12 patients, the Hospice failed to assure all disciplines comprising of the IDG (Interdisciplinary group) contributed to the patient's comprehensive and ongoing assessments and care planning process. Findings include:	L 541	POC accept 12.20.18 GC/SL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: CEO
(X6) DATE: 12.18.2018

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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L 541	Continued From page 1 During days of survey, the pastoral contribution for Patients #1 through #12, who received Hospice services from August 2017 through present, was not demonstrated in the medical records. Per the Hospice Clergy Agreement, the spiritual counselor is to contribute to the IDG with on-going assessments, develop, review and revise care plans. In addition, the Hospice Clergy can also contribute to the evaluation of care, discharge planning and consultation with other clergy and staff. The medical records, as well as the IDG meeting notes, did not show evidence of input or participation by the spiritual counselor for greater than half of the total bi-weekly meetings during this time period. Per interview, the Hospice Manager and Bereavement Counselor acknowledged that although staff were providing patient and family spiritual needs consistent with their beliefs and acceptance of this service, the pastor "comes when [he/she] can" and confirmed" not being present all the time" at the IDG. In addition, it was also noted the Hospice Medical Directors were not in attendance at all IDG meetings from 12/12/17 through 11/13/18. Although the Medical Director is required to attend each IDG meeting, there was no evidence a physician was in attendance on 2/21/18; 5/16/18; 5/29/18; 8/8/18 & 10/16/18. This is confirmed by reviewing the minutes of the IDG meetings and during interview with the Hospice Director.	L 541		
L 602	FURNISHING OF NON-CORE SERVICES CFR(s): 418.70	L 602		

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L 602	Continued From page 2 A hospice must ensure that the services described in §418.72 through §418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in §418.100. These services must be provided in a manner consistent with current standards of practice. This STANDARD is not met as evidenced by: Based on staff interview and record review, a hospice nurse failed to follow professional practice and hospice policy during the provision of care for 1 applicable patient. (Patient #10) Findings include: 1. Per record review, the health of hospice Patient #10 had declined and s/he was unable to be transported to a physician's office to receive a pneumococcal vaccine. Per hospice nurse progress note, on 10/24/18 the assigned hospice nurse states the Primary Care Physician's (PCP) office was going to provide the hospice nurse with the vaccine so s/he can administer the injection to Patient #10. Upon arrival to the PCPs office, staff provided the hospice nurse with the medication, however upon arrival to Patient #10's apartment, the hospice nurse noted the PCP's office staff had only provided an empty vial without the vaccine solution. The hospice nurse returned to the PCP's office and was then provided with a syringe filled with a solution, which the nurse described as "...the immunization". The hospice nurse returned to the patient's apartment and administered "the immunization" to Patient #10. There was no evidence the hospice nurse witnessed the drawing up of the vaccine or validated that the label read (to include medication name and/or dose) on the vial was indeed the pneumococcal vaccine, and	L 602		

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L 602	Continued From page 3 proceeded to administer to Patient #10 the solution in the syringe. Per review of the policy Medication Administration and Assistance last approved on 7/21/11 states: "Procedure #5 The nurse will be responsible for knowing the drug indications, contraindications, adverse effects, interactions, and proper dosing and administration information.....". However, the lack of validation of content of syringe provided by the PCP's office, the hospice nurse failed to follow agency policy and also failed to maintain current professional standards. Per interview on the afternoon of 11/27/18, the Hospice Program Manager confirmed the former hospice nurse failed to follow policy and professional standards. Per the Institute of Health Care Improvement: " One of the recommendations to reduce medication errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time". The hospice nurse's process for receiving and administration of the medication failed to validate if the medication administered was the right drug and/or right dose.	L 602		

L541 Approach to Service Delivery

Action to resolve deficiency:

1. One or more additional contracts for pastoral or other counselor shall be secured.
2. Attendance requirements for participation in the Interdisciplinary Group will be reviewed with all membership.

Timeline and Person Responsible:

January 15, 2018 - Hospice Manager

Monitoring Plan: The Hospice Manager will review attendance records monthly to assure compliance with standard is met.

L602 Furnishing of Non-Core Services

Action to resolve deficiency:

1. Competency assessment tool and process will be developed.
2. Nursing staff will be educated on policies of medication administration and the 5 Rights of Medication Administration.
3. Nursing staff will complete competency assessment and remediation provided, if needed.
4. Medication administration competency will be added to new employee orientation training and checklist

Timeline and Person Responsible

January 15, 2018 - Hospice Manager

Monitoring Plan: Direct observation of nursing practice during supervisory or coaching visits.

Janet L McCarty
12.18.2018

POC amnt GC/SL 12.20.18