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

August 24, 2018

Judy Peterson, Director
Vna Of Chittenden & Grand Isle Counties
1110 Prim Road
Colchester, VT 05446

Provider ID #:471500

Dear Ms. Peterson:

Enclosed is a copy of your acceptable plans of correction for the recertification hospice survey conducted on **August 1, 2018**.

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

Sincerely,

Suzanne E. Leavitt RN, MS

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

Enclosure

PRINTED: 08/10/2018
FORM APPROVED
OMB NO. 0938-0391

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 |
|---|---|---|---|
| | 471500 | A. BUILDING _____ B. WING _____ | 08/01/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VNA OF CHITTENDEN & GRAND ISLE COUNTIES | 1110 PRIM ROAD COLCHESTER, VT 05446 |

| (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<br><br>At the time of the re-certification Hospice Survey conducted by the Division of Licensing and Protection on 7/30/18 - 8/1/18 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 | VNA of Chittenden and Grand Isle provides this plan of correction without admitting or denying the validation or existence of the stated deficiency. The plan of correction is prepared and executed as a requirement of federal and state law. | |
| L 000 | INITIAL COMMENTS<br><br>An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 7/30/2018 and 8/01/2018. The following issues were identified by the survey team. | L 000 | | |
| L 555 | COORDINATION OF SERVICES<br>CFR(s): 418.56(e)(2)<br><br>[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-]<br>(2) Ensure that the care and services are provided in accordance with the plan of care.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the Hospice failed to ensure that care/services were provided to clients based on the plan of care (POC) for 3 of 14 clients in the applicable sample. (Client #8, #10 and #11). Findings are detailed below:<br><br>1. Review of the electronic medical record (EMR) for client #10 has physician orders for Hospice Aide (HA) visits two times a week for 12 (twelve) weeks, during the certification period | L 555 | re: L555<br>Client #8, #10, and #11 were not negatively impacted by the frequency of visit orders and provided services. In each instance, the patient was informed and involved in decision-making related to frequency of visits. It was an administrative oversight to not verify the orders reflected needs. Hospice IDG will ensure review of frequency of orders matching delivered services and will update plan of care accordingly.<br><br>During the time-frame under review, our Hospice Chaplains began entering their orders and providing visit frequencies, which was a new practice towards ensuring interdisciplinary work and collaborative communication.<br><br>POC sent 8.24.18<br>GC/sd | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X8) DATE

Angel Mennis, MS — VP of Quality + Education — 8/17/18

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.

Sara Graham, LICSW, LNHA — EXECUTIVE DIRECTOR HOSPICE — 8/17/18

PRINTED: 08/10/2018
FORM APPROVED
OMB NO. 0938-0391

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 |
|---|---|---|---|
| | 471500 | A. BUILDING _____ B. WING _____ | 08/01/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VNA OF CHITTENDEN & GRAND ISLE COUNTIES | 1110 PRIM ROAD COLCHESTER, VT 05446 |

| (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 |
|---|---|---|---|---|

L 555 Continued From page 1

2/18-5/21/18 and two times a week for 13 (thirteen) weeks during the re-certification period 5/16-8/16/18. Between 3/11/18 and 3/17/18 there was only one scheduled visit and during the weeks of 4/1/18 and 4/7/18 and 7/8/8 and 7/14/18 the HA was scheduled twice and documentation states that the HA canceled due to "short staffing" on 3/13/18, 4/3/18 and 7/10/18. There is no evidence that another visit was scheduled to provide the twice a week visit. This is confirmed by the Executive Director of Hospice during an interview on 8/1/18 at 11:13 AM.

2. Per medical record review, Client #11 has physician orders for weekly nursing visits. Between 6/15/2018 and 6/29/2018 no nursing visits were made. There is no documentation that reflects why a visit was missed, that the MD was notified or that the visit frequency was changed. This is confirmed with the Executive Director during interview on 8/1/2018.

3. Per medical record review Client #8 has orders dated 2/2/2018 for chaplain visits every other week. This was a change from weekly chaplain visits ordered on admission on 10/23/2017. Between 11/2017 and 4/2018 chaplain visits were made monthly. There is no documentation to reflect that visits did not follow the physician orders or that the physician was notified of the decrease in frequency. This is confirmed with the Executive Director during interview on 8/1/2018.

L 596 COUNSELING SERVICES
CFR(s): 418.64(d)(1)

Counseling services must include, but are not limited to, the following:

L 555 re: L555 (cont)

VNA will be upgrading the plan of care and assessment components within the EMR which will more easily track consistency of orders and visits. Estimated implementation date of December 2018. Until transition has happened, RN case managers will verify frequency of LNA and RN visits are met while reviewing and preparing for IDG, all other disciplines will do the same (SW, Chaplain, Volunteer Services, Bereavement services)
Hospice Educator to provide re-education to full IDG re: orders and frequency of visits by September 14, 2018.

VNA will continue to provide the frequency of visits outlined in the comprehensive assessment and plan of care regardless of staffing issues.

VNA auditor will audit 25% of records monthly for 6 months and if ongoing compliance is met, will reduce audits to 10% monthly.

POC sent 8/24/18
GC/sl

L 596

PRINTED: 08/10/2018
FORM APPROVED
OMB NO. 0938-0391

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 |
|---|---|---|---|
| | 471500 | A. BUILDING _____ B. WING _____ | 08/01/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VNA OF CHITTENDEN & GRAND ISLE COUNTIES | 1110 PRIM ROAD COLCHESTER, VT 05446 |

| (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 |
|---|---|---|---|---|
| L 596 | Continued From page 2<br>(1) Bereavement counseling. The hospice must:<br>(i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.<br>(ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care.<br>(iii) Ensure that bereavement services reflect the needs of the bereaved.<br>(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in §418.204(c).<br><br>This STANDARD is not met as evidenced by:<br>Based upon record review and interview The Hospice failed to make bereavement services available to the family and other individuals per the bereavement plan of care up to 1 year following the death for 3 of 6 patients. (Patient # 4, # 5 and #14). Findings include:<br><br>Per interview on 07/31/18 at 2:55 PM the Hospice Bereavement Coordinator (HBC) stated the plan of care (POC) for bereavement is communicated during the IDG meeting (Interdisciplinary group). The initiation of the POC is noted in the electronic charts (E-chart) following the death. The HBC further indicated the documentation of the provision of bereavement services is found either in the e-chart or hardcopy binder. | L 596 | re: L596<br>VNA will be implementing a new Bereavement Services feature within the EMR. This electronic program will automatically generate a bereavement plan of care at the time of death and specify recommended interventions with frequencies. This will more readily demonstrate compliance.<br><br>This will be implemented by the end of November 2018 and replace all paper records for Bereavement Services.<br><br>Bereavement Coordinator will develop a network of volunteers to support timely mailings and follow up.<br>Bereavement Coordinator will engage with existing team members (Volunteer, Chaplain and SW) to do initial bereavement follow up and development initial bereavement plan of care. This will begin the week of August 20, 2018.<br><br>POC sent 8.24.18 GC/SL | |

PRINTED: 08/10/2018
FORM APPROVED
OMB NO. 0938-0391

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 |
|---|---|---|---|
| | 471500 | A. BUILDING _____ B. WING _____ | 08/01/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VNA OF CHITTENDEN & GRAND ISLE COUNTIES | 1110 PRIM ROAD COLCHESTER, VT 05446 |

| (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 |
|---|---|---|---|---|
| L 596 | Continued From page 3 | L 596 | | |

Per the bereavement program, "Coping with Grief" pamphlet will be sent to the family/individual several weeks after the death followed by a telephone call, approximately 4 weeks later. Additional follow up information is sent via pamphlets and/or letters at intervals of 3, 6 and 12 months.

For three charts reviewed, there was no evidence that the POCs for bereavement services were implemented, as follows:

1. Patient #4 died approximately 8 months ago. The electronic chart shows the POC as "initiate - will contact". Per review of the binder, demonstrates an attempt to contact via telephone several weeks later. However, there was no further information documented whether the bereavement services were continued as noted above or whether the needs of the bereaved were met.

2. Patient #14's [who died 9 months ago] bereavement POC stated "will follow up". However, no further information noted via binder nor chart if the POC or an appropriate follow up was conducted. Per interview at that time, the HBC acknowledged that sometimes there is not always a home address and was unable to state if further telephone attempts were made

3. Based on staff interview and record review, the Bereavement Coordinator confirmed there was a failure to establish contact with the family of Client #5 who expired in August 2017. Client #5 and family was assessed at the time of Hospice admission to have "Moderate Bereavement" needs demonstrating: " ...signs of normal grieving, limited supports, some resources, some

re: L596 (cont)
Hospice Educator will provide re-education to the IDG re: compliance with bereavement services and their role in ensuring contact information is secured at time of admission. This will occur by September 7, 2018.

Beginning, September 2018, Patient Care Coordinators with support from Hospice Educator will audit 10% of bereavement records to ensure bereaved family members needs are met timely and that the Bereavement Program is in compliance with federal and state regulations. Audits will continue until 4 months consecutive are in full compliance.

POC audits 8.24.18
GC/GL

PRINTED: 08/10/2018
FORM APPROVED
OMB NO. 0938-0391

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 |
|---|---|---|---|
| | 471500 | A. BUILDING _____ B. WING _____ | 08/01/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VNA OF CHITTENDEN & GRAND ISLE COUNTIES | 1110 PRIM ROAD COLCHESTER, VT 05446 |

| (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 |
|---|---|---|---|---|
| L 596 | Continued From page 4<br>stresses, children poorly prepared/aware ...". However, bereavement follow-up consisted of only 1 phone call on 12/29/17, 3 months after Client #5 had expired. Per interview on 7/31/18 at 3:25 PM, the Bereavement Coordinator stated s/he did not have a phone number and should have pursued contact with the family earlier as required.<br><br>The Hospice Bereavement Coordinator (HBC) confirmed during interview at that time, that bereavement services per the program, were not consistently provided within the noted timeframe's nor was there evidence of the effectiveness of the bereavement services. | L 596 | | |
| L 619 | COMPETENCY EVALUATION<br>CFR(s): 418.76(c)(5)<br><br>(5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met.<br><br>This STANDARD is not met as evidenced by:<br>Based on file review and interview, the hospice failed to demonstrates that the annual performance evaluations were met for 2 of 5 LNA's reviewed. Finding include:<br><br>1. Per record review of the LNA's competencies and annual review for the past year, two LNA's did not have documentation to show that this requirement was met. Per interview on 08/01/18 at 12:21 PM The Hospice Director confirmed there was no annual performance evaluation documentation for two LNAs | L 619 | re: L619<br>Clinical Manager/Director will complete all outstanding annual staff reviews by September 30, 2018. Clinical managers will deliver annual reviews in the month of date of hire anniversary for all staff.<br>VNA Human Resource Department will send monthly reports to clinical manager/director to ensure timely completion and compliance with regulations.<br>VNA Human Resources Department will audit personnel records of Hospice Team quarterly for compliance. | |
| L 679 | AUTHENTICATION<br>CFR(s): 418.104(b) | L 679 | Pc amt 8/24/18<br>GC/d | |

PRINTED: 08/10/2018
FORM APPROVED
OMB NO. 0938-0391

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 |
|---|---|---|---|
| | 471500 | A. BUILDING _____ B. WING _____ | 08/01/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VNA OF CHITTENDEN & GRAND ISLE COUNTIES | 1110 PRIM ROAD COLCHESTER, VT 05446 |

| (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 |
|---|---|---|---|---|
| L 679 | Continued From page 5<br>All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview the medical record for 1 out of 14 patients did not have clear, complete or legible entries in the medical record. (Patient #14) Findings include:<br><br>1. Review of Patient #14's medical record, a case communication note indicated that the listed Durable Power of Attorney (DPOA) who was also a social worker that was employed by the facility, pronounced the death. However, The communication note stated 'telephone call [facility] client died yesterday...pronounced by [name of the DPOA, SN] at 3:50 PM'. During interview on 07/31/18 at 4:21 PM, the HHA Director stated "I think the note is confusing, that's not right, I'll have to find out'.<br><br>Per the Hospice Policy, Utilization 9.4 Pronouncement of Death, #1 A registered nurse is allowed to pronounce the death.." However neither a family member nor a social work is listed as being able to. In addition, #7 Documentation, denotes several items that must be included in the Death visit note. The documentation in the patient's record had none of the information as required by the Guidelines.<br><br>The Hospice Director on 08/01/18 stated they were not made aware of the death until the next day however, the facility RN did make the pronouncement. The Hospice Director confirmed that the information in the record was not clear, complete or accurate. | L 679 | re: L679<br>In the event that IDG members understand that documentation did not reflect actual events, an addendum to the note will be entered to clarify information.<br>Hospice Clinical Manager with support from Hospice Educator will provide re-education to all staff about professional documentation and standards of practice. This re-education will occur by September 7, 2018.<br><br>POC emt 8/24/18 OC/RL | |

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

PRINTED: 08/10/2018
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 471500 | A. BUILDING _____ B. WING _____ | 08/01/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VNA OF CHITTENDEN & GRAND ISLE COUNTIES | 1110 PRIM ROAD COLCHESTER, VT 05446 |

| (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 |
|---|---|---|---|---|

Visiting Nurse Association
of Chittenden and Grand Isle Counties



August 17, 2018

Ms. Suzanne Leavitt, RN, MS
Assistant Division Director
Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

Dear Ms. Leavitt:

The Division of Licensing and Protection conducted a survey on August 1, 2018 to determine Federal compliance for our Hospice Program. Attached is the Corrective Action Plan for the deficiencies identified during the survey. If you have questions regarding the plan, please do not hesitate to contact me at (802) 860-4412 or means@vnacares.org.

Sincerely.

Angel Means, RN, MS
VP of Quality and Education
VNA of Chittenden and Grand Isle Counties