VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

ivision 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

February 25, 2019

Ron Cioffi, Administrator
Vna & Hospice Of The Southwest Region Inc
7 Albert Cree
Rutland, VT 05701-4648

Provider ID #:477007

Dear Mr. Cioffi:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 5, 2019**.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 477007 | A. BUILDING _____ B. WING _____ | C 02/05/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VNA & HOSPICE OF THE SOUTHWEST REGION INC | 7 ALBERT CREE RUTLAND, VT 05701 |

| (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 |
|---|---|---|---|---|
| G 000 | INITIAL COMMENTS<br><br>An unannounced investigation of three complaints was conducted by the Division of Licensing & Protection on 2/4 & 5/2019. The following regulatory deficiency was identified: | G 000 | | |
| G 436 | Receive all services in plan of care<br>CFR(s): 484.50(c)(5)<br><br>Receive all services outlined in the plan of care. This ELEMENT is not met as evidenced by:<br>Based on record review and staff interviews the agency failed to assure that patients receive all services outlined in the plan of care for one Patient #1. Findings include:<br><br>Per record review the Physician ordered and the Plan of Care stated Home Health Aide (HHA) services were to be provided twice a week. The days stated were Tuesday and Thursday. Patient #1 was admitted for rehabilitation following a hospitalization for Acute Bilateral Extremity Cellulitis. The agency provided Skilled Nursing, Physical Therapy, Social Work, Occupational Therapy, and Home Health Aide services. As goals were met the services were discontinued. Skilled nursing was discontinued first with goals met. The Physical Therapist (PT) became responsible for supervision at that time and the Occupational Therapist (OT) took over supervision when PT was discontinued. All goals were met at the time of discharge. There was no evidence in supervision notes that the patient had expressed concern about her services. There were also no physician orders to reduce the number of visits and no changes to the plan of care.<br>In a review of visits, documented in the electronic medical record (EMR), it is found that there were | G 436 | G436 Plan of correction:<br>The temporary scheduler that was working during the time of the identified missed visits is no longer in this role.<br>Staff will be formerly re-educated on 2/21/2019 by manager Joyce Humphrey. The education will include:<br>1) When visits are canceled by the agency or patient this needs to be documented in the patient's record. When visits are canceled by the agency; the patient must be offered an alternative date and/or staff member as appropriate (and document).<br>2) The MD is to be notified of any changes with subsequent documentation of such.<br>3) If the patient refuses an alternate date, a Home Health Change of Care Notice (HHCCN)<br>2/22/19 POC accept 2.22.19 MH/SL | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Director of Home Care | 2-21-19 |

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 436 | Continued From page 1<br>visits missed on 3 occasions. Those visits would have occurred on 8/28/18, 9/4/18, and 9/11/18. There is a scheduler note stating that a missed HHA visit on 9/3/18 was due to an agency Holiday. No documentation was found indicating that a replacement visit was ordered. A fourth visit was explained by a note stating that the patient canceled because her regular HHA wasn't available.<br>In an interview on 2/5/18 at 10:50 am the Clinical Manager of Home Care Services confirmed that there was no documentation to explain the missed visits and that there should have been a visit offered and documented to replace the Holiday. Additionally there were no Physician orders or changes to the Plan of Care in the EMR to change the visit frequency. | G 436 | G436 Plan of Correction continued:<br><br>will be completed and signed by the patient.<br>4) Changes to visit frequency require that there is an MD order and supporting documentation.<br>5) To prevent these events from recurrence, the manager will educate on an ongoing basis (aides and schedulers) as well as conduct documentation audits.<br><br>2/22/19 POC amnt MH/SI | |