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

September 15, 2017

Ronald Cioffi, Administrator
Rutland Area Visiting Nurse Association & Hospice
1128 Monument Avenue
Bennington, VT 05201

Provider ID #:471507

Dear Mr. Cioffi:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 23, 2017**.

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
	471507	A. BUILDING _____ B. WING _____	08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND AREA VISITING NURSE ASSOCIATION & HOSPICE,	1128 MONUMENT AVENUE BENNINGTON, VT 05201

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L 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection from 8/21 - 8/23/17. The following regulatory deficiencies were identified.	L 000		
L 523	418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24. This STANDARD is not met as evidenced by: Based on medical record review and staff interviews between 08/21 through 08/23/17, the Hospice failed to ensure that there was consultation with the other members of the interdisciplinary group [IDG] to consider the information gathered from the initial assessment for developing an individual plan of care within the first five days. This finding applied to 7 of 13 patients sampled (# 1, 2, 3, 4, 5, 6, and 11). Findings include: 1. Per record review of Patient #1, who was admitted to Hospice services in September 2016, and Patient #3 admitted in December 2016, there was no evidence that the Registered Nurse, in consultation with the other members of the IDG, considered the information gathered from the initial assessment to develop the plan of care. No information was found in the record of the group's decision on who should visit the patient/family during the first 5 days of hospice care in	L 523	See Attached plan of correction POC amptr 9.14.17 L523-L668 KC/SG	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Director of Hospice & Palliative Care	9/11/2017

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.

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

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L 523	Continued From page 1	L 523		

accordance with patient/family needs and desires. The Clinical Coordinator stated that a voice mail is left on each member's phone line, but acknowledged there is no record of what was discussed and/or verified for the plan of care by the IDG members for Patient #1 and #3.

2. Patient #2 was admitted to Hospice services in the beginning of May 2017. The IDG meeting was noted on 05/09/17. There was no evidence that the IDG members were consulted to develop the comprehensive assessment/care plan prior to the initial meeting. Per interview on 08/23/17 at 2:10 PM the Hospice Program Director (HPD) stated the expectation is that the nurse document in either the patient's Admission note and/or the Case Communication note, that IDG member were consulted/contributed to the plan of care. The HPD confirmed the above at this time.

3. Patient #4 was admitted to Hospice in July 2016. The first documented IDG meeting discussing this patient was conducted on 8/10/16, which was 21 days after admission. There was no documented evidence that the IDG team had discussed the initial assessment by the nurse to determine the services needed and to develop the plan of care. The HPD confirmed that there was no documentation that the patient's case had been evaluated by the IDG team within five days of the initial assessment, and there was no evidence they had discussed this case before the first documented meeting notes 21 days after admission.

4. Patient #5 was admitted to Hospice at the end of December/2016. Per review of the patient's record, there was no evidence that the IDG members were consulted to develop the

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L 523	Continued From page 2 comprehensive assessment/care plan prior prior to the initial meeting which took place on 1/16/17. Per interview on 08/23/17 at 1:55 PM the Hospice Program Director (HPD) stated the expectation is that the nurse document in either the patient's Admission note and/or the Case Communication note, that IDG members were consulted/contributed to the plan of care. 5. Patient #6 was admitted to the Hospice program at the end of September 2016. The first documented IDG meeting discussing this patient was conducted on 10/5/16, which was 7 days after admission. There was no documented evidence that the IDG team had discussed the initial assessment by the nurse to determine the services needed and to develop the plan of care. The HPD confirmed that there was no documentation that the patient's case had been evaluated by the IDG team within five days of the initial assessment. 6. Patient #11 was admitted to the Hospice program on 3/9/17. The first documented IDG meeting discussing this patient was conducted on 3/15/17, which was 6 days after admission. There was no documented evidence that the IDG team had discussed the initial assessment by the nurse to determine the services needed and to develop the plan of care. The HPD confirmed that there was no documentation that the patient's case had been evaluated by the IDG team within five days of the initial assessment.	L 523		
L 533	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice	L 533	See completed plan of correction Attached	

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L 533	Continued From page 3 interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. This STANDARD is not met as evidenced by: Based upon record review and interview the Hospice failed to demonstrate that an assessment update occurred no less frequently than every 15 days for 2 of 13 patients in the sample (Patient #1 and #4). Findings include: 1. Per interview and record review there is no evidence that all members of the Interdisciplinary Group (IDG) were actively involved in evaluating Patient #1's care, during the month of October 2016. Patient #1 was admitted in September 2016, however there were no IDG care plan notes found in the patient's record or elsewhere for the month of October 2016. This was confirmed on 08/21/17 at 4:15 PM by the Clinical Coordinator. 2. Per review of the record of Patient #4, there was no evidence that the IDG discussed this case until 21 days after the admission in July 2016. On 8/23/17, the Hospice Program Director confirmed that there were no prior notes to indicate the case discussion had occurred sooner for Patient #4.	L 533		
L 541	418.56(a)(1)(i)-(iv) APPROACH TO SERVICE DELIVERY	L 541	See attached plan of correction	

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L 541	Continued From page 4	L 541		

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 record review and staff interview, the Hospice failed to have documentation that one or more core members consistently contributing to all the interdisciplinary group (IDG) meetings for 13 of 13 sampled records. (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12,and #13). Findings include:

Per record review and confirmed through interview, not all IDG core members contribute to the patient's comprehensive and ongoing assessments and care planning process, on an approximately every 2 week basis, as follows:

a) Patient #1 (Hospice service from September 2016 - January 2017) had no documentation of the IDG meetings in October 2016, nor was the social worker contributing in the month of December 2016.

b) Patient #2's Start of Care (SOC) in May 2017, demonstrates as evident by documentation that the social worker was not present during the May 9th and 23rd, June 27th, and July 10th IDG meetings.

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c) Patient #3 (SOC December 2016) records demonstrate no social worker present in December (6th& 20th), January 3rd, March (13 & 28th) and in May 16th the physician and spiritual/clergy was absent as well.

d) Patient # 4 (SOC July 2016) had missing IDG meeting notes between 9/7/16 and 10/5/16, and also between 1/11/17 and 2/8/17. There is no evidence that this resident was discussed every 2 weeks as required.

e) Per review of IDG meetings and the comprehensive assessment and plan of care specifically for both Patient #5 (SOC December 2016) and Patient #13 (SOC June 2017) indicate an absence, by signature, of the Hospice Program Medical Director, a required member of the IDT core group. When Patient #5 was reviewed by the IDT on 2/1/17 and 2/14/17 attendance by the Hospice Medical Director was not met. When Patient #12 was reviewed during IDG meetings for 7/11/17, 7/25/17 & 8/9/17 there was also a lack of attendance by the Hospice Medical Director. At each IDT meeting, all attendees must sign the attendance sheet, acknowledging they have reviewed each patient's Hospice comprehensive assessment and any changes made to the Plan of Care.

f) Patient #6 was admitted at the end of September 2016. The IDG meeting notes did not have the signature of the Hospice Medical Director on 10/12/16, 12/21/16, 1/4/17, 2/1/17, 2/15/17, 3/29/17, 4/12/17, and 5/24/17. The Social Worker's signature was missing from the following meetings regarding Patient #6: 10/26/16, 1/18/17, 2/1/17, 2/15/17, 3/1/17,

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L 541	Continued From page 6	L 541		

3/15/17, 3/29/17, 4/12/17 and also on 8/16/17. The Hospice Program Director confirmed that there was no evidence that these core members had attended the meetings as required.

g). Patient #10's (SOC - June 2017) record demonstrates no physician signature of the July 11th and August 8th IDG meetings. It is not clear from the record, if the physician was or was not in attendence.

h) Patient #11 (SOC March 2017) had IDG meeting notes that were missing the signature of the Hospice Medical Director on 3/29/17, 4/12, 5/10, 5/24, 6/7, 6/21, 7/5, 7/19, and 8/16/17. The Social Worker's signature was missing on 3/15/17, 3/29, and 4/26/17. This was also confirmed by the HPD.

i) Patient #7 has a start of care (SOC) date of 7/5/17 the IDG meeting notes were missing the signatures of the Medical Director on 7/26/14 and 8/9/17 (2 of 3 meetings).

j). Patient #8 has a SOC date of 11/2/16 the IDG meeting notes were missing signatures of the Medical Director on 11/23/16, 12/21/16, 1/4/17, 1/18/17, 2/1/117, 3/1/17, 3/29/17, 4/12/17, 4/26/17, 5/10/17, 5/24/17, 6/21/17, 7/5/17, 7/19/17, 8/2/17 & 8/16/17 (16 0f 20 meetings). The Social Worker signatures were missing for 12/21/16, 1/4/17, 1/18/17, & 2/1/17 (4 of 20 meetings)

k). Patient #9 has a SOC date of 1/17/17 the IDG meeting notes were missing the signatures of the Medical Director on 2/15/17, 3/29/17, 4/12/17, 4/26/17, 5/10/17, 5/24/17, 6/21/17, & 8/16/17 (8 of 15 meetings).

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L 541	Continued From page 7	L 541		

Per interview with the Clinical Coordinator in a branch office on 08/21/17 at 4:15 PM confirmed "there was a time period when we didn't have a social worker available for the IDG meetings". The Hospice Program Director acknowledged on 08/23/17 at 12:30 PM that the expectation is that the members sign off on the IDG minutes sheet and "it is hard to tell when they [members] are in attendance if they don't sign the sheet".

L 594 418.64(c) MEDICAL SOCIAL SERVICES

L 594 See attached plan of correction

Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.

This STANDARD is not met as evidenced by:
Based record review and staff interview, the agency failed to ensure the medical Social Services were provided per the plan of care for 1 of 13 patients sampled (Patient # 4) Findings include:

Per review of Patient #4, who was admitted in October 2016, the registered nurse completing the assessment identified a need for Social Work services as part of the Plan of Care (POC). The signed POC also stated MSW support as part of the plan. Per review of the disciplines visiting the patient, there was no documentation of the MSW making a visit to the patient, or any notes to indicate a refusal of this service by the patient.

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L 594	Continued From page 8 On 8/23/17, the Hospice Program Director confirmed that no Social Worker visits were made to Patient #4 as part of their identified needs in the initial assessment by the nurse and as stated in the POC.	L 594		
L 642	418.78 VOLUNTEERS The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee. This STANDARD is not met as evidenced by: Based on interview and review of policy, the Hospice failed to consistently supervise the volunteers. This has the potential to effect all patients who receive volunteer services. Findings include: 1. Per interview on 08/21/17 at 4:15 PM the Hospice Volunteer Coordinator (HVC) in a branch office stated that the Hospice has approximately sixty volunteers, but less than half of the volunteers provide direct patient contact. The HVC stated that supervision is provided by contacting the volunteers for their hours worked and "asking them how everything is going". HVC also stated that there is opportunity for the volunteers during monthly meetings to give updates but acknowledged that not all volunteers attend these. Volunteers are also given a package with reading and question materials, regarding Hospice information, "but is reviewed when they have a question". Per review of the Hospice's policy and process for supervision, [H.R.V45- Volunteer Supervision #5] denotes that the Volunteer Coordinator	L 642	See attached plan of correction	

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L 642	Continued From page 9 "provides an annual performance evaluation for each volunteer.... with "a summary of his/her observation and supervision of the volunteer". During interview with the Hospice Volunteer Coordinator-Main Office (HVC-M) on 08/22/17 at 3:45 PM, they stated that the volunteers can call anytime if they need or have a concern and will get feedback from families, but acknowledged this is not consistent for all volunteers. The HCV-M confirmed the annual evaluations have not been done and supervision has not always been consistent.	L 642		
L 662	418.100(g)(2) TRAINING (2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties. This STANDARD is not met as evidenced by: Based on record review and staff interviews the agency failed to assure that an orientation that addresses the hospice employee's specific job duties was provided to six randomly chosen Hospice Aides. Findings include: Per record review of 6, randomly chosen, Hospice Licensed Nurse Aides (LNA's) there is no evidence of a specific Hospice orientation which addressed the specific job duties. In an interview on 8/23/17 the Hospice Program Director confirmed that though there is a portion in general orientation, for all LNA's, there is no training for LNA's which describes the specific duties and aspects of end-of-life care.	L 662	See attached plan of correction	
L 668	418.102(c) RECERTIFICATION OF THE TERMINAL ILLNESS	L 668	See attached plan of correction	

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L 668	Continued From page 10 Before the recertification period for each patient, as described in §418.21(a), the medical director or physician designee must review the patient's clinical information. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that a physician face to face visit was made for a recertification for 1 of 13 patients (Patient #4). Findings include: Per record review of Patient #4, there was a requirement for a face to face physician visit and documention before the patient could be recertified on 5/15/17. Due to the document not being completed in a timely manner, Patient #4 was asked to revoke their Hospice Benefit on 5/15/17 temporarily until the physician's document could be completed. Although there was a visit scheduled on 4/14/17 for the Nurse Practitioner to complete the necessary face to face visit, this was not made at that time. The delay caused the resident to not be able to be recertified as scheduled on 5/15/17, and they had to be readmitted on 5/19/17 after the document was completed. The Hospice Program Director stated that the requirement had not been met for the face to face visit and this was the only factor contributing to the to discharge and readmission of Patient #4.	L 668		

September 8, 2017
Rutland Area Visiting Nurse Association & Hospice

L 523 418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT

Plan of Correction:

Skilled Nurse education was completed on August 30, 2017 with all Rutland and Manchester staff regarding the process of polling on admission. The same education will occur with the Bennington staff on September 12, 2017. Staff will send a case communication note in our EMR to all members of the Interdisciplinary Group (IDG) after an admission is completed. This will ensure the plan of care identified in the initial assessment is communicated within the first five days of hospice care. The hospice clinical managers who already audit every admission will add this case communication note to their list for admissions. The results will be presented to the Quality Assessment and Performance Improvement Committee at least quarterly.

L 533 418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT

Plan of Correction:

The Hospice Clinical Managers will ensure that each patient's plan of care is updated no less frequently than 15 days. They will also ensure that the signed IDG forms are placed in the patient's medical record. Education to the Clinical Managers on this process was completed on September 7, 2017 by the Hospice Director.

L 541 418.56(a)(i)-(iv) APPROACH TO SERVICE DELIVERY

Plan of Correction:

All IDG meetings will be attended by the required core members. If members are participating via telephone or with faxed information, the IDG form will reflect that. Absent members also will be reflected on the IDT form. Education provided to Hospice Clinical Managers by the Hospice Director on September 7, 2017. Education to all IDG members will be completed by September 13, 2017.

L 594 418.64(c) MEDICAL SOCIAL SERVICES

Plan of Correction:

Hospice Director will provide education to all Hospice Social Work staff by September 13, 2017, regarding the following process. When a social work need is identified, whether at the time of admission or otherwise, they are responsible for making contact with the patient and/or family to arrange an initial

visit. If the patient and/or family refuse social work services or contact fails to be made, the documentation in the medical record will indicate this. Additionally, if subsequent visits are not made, the reason for this will be documented in the medical record and communication with the IDG will occur to update the plan of care.

L 418.78 VOLUNTEERS

Plan of Correction:

Volunteer coordinators will ensure consistent supervision of all volunteers beginning September 11, 2017, by creating and maintaining a log of feedback from patients and families, as well as observations from the volunteer coordinators themselves. The information gathered will be communicated with the volunteers when indicated and will be included in their annual evaluation. The Hospice Director will audit the logs and sign off on them quarterly.

L 662 418.100(g)(2) TRAINING

Plan of Correction:

Hospice Director will coordinate with Home Care Aide (HCA) staffing managers to ensure completion of a hospice specific competency assessment for all HCAs before providing care to hospice patients. All HCA staff hired after September 25, 2017 will receive this training as part of their orientation. All currently employed HCA staff will have a competency assessment completed by their managers by November 30, 2017. These files will be sent directly to Human Resources on completion for placement in personnel files.

L 668 418.102(c) RECERTIFICATION OF TERMINAL ILLNESS

Plan of Correction:

All patients requiring a face to face visit for recertification of terminal illness will have one completed by the Hospice Physician or Hospice Nurse Practitioner no more than 30 days prior to the start of the benefit period. Beginning September 11, 2017, the Hospice Clinical Managers will log and track when recertifications and face to face visits are due and then will coordinate with the Hospice Physician or Hospice Nurse Practitioner to ensure timely completion.

VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
HC 2 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 31, 2017

Ronald Cioffi, Administrator
Rutland Area Visiting Nurse Association & Hospice,
1128 Monument Avenue
Bennington, VT 05201

Dear Mr. Cioffi:

The Division of Licensing and Protection conducted a survey at your agency on **August 23, 2017.** The purpose of the survey was to determine if your agency was in compliance with Federal participation requirements for Home Health and Hospice Agencies participating in the Medicare and Medicaid programs. As a result, found and require a plan of correction.

Please write or type your plan of correction including a correction date in the space provided on the enclosed CMS-2567 form. Please **sign, date, and return** this report to this office no later than **September 13, 2017**

Plan of Correction (POC)

Your POC must contain the following:

- What action you will take to correct the deficiency;
- What measures will be put into place or what systemic changes you will make to assure that the deficient practice does not recur; and,
- How the corrective actions will be monitored so the deficient practice does not recur.

You are reminded that deficiency forms are available to the general public after a specific period of time. Therefore, please be specific in your statements concerning corrective actions. If you have any questions regarding the deficiency statement please do not hesitate to contact me at (802) 241-0480.

Sincerely,

Suzanne E. Leavitt RN, MS

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