

Division of Licensing and Protection
103 South Main Street
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 30, 2014

Celine McGill, Administrator
Bayada Home Health Care
80 Pearl Street
Essex Junction, VT 05452-3668

Provider ID #:477019

Dear Ms. McGill:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 13, 2014**.

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

Sincerely,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
Director State Survey Agency

Enclosure

FK:kc



SEP 05 2014

PRINTED: 08/20/2014
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: 477019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/13/2014
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NAME OF PROVIDER OR SUPPLIER BAYADA HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 80 PEARL STREET ESSEX JUNCTION, VT 05452
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(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	G 000	Bayada completed a self-report regarding a concern expressed by a client relating to catheter insertion. Bayada conducted investigating into the incident and found that the RN did not adhere to Bayada policy 0-1237 Catheterization and Management- Urinary Catheters. RN was removed from the case, counseled, and re-educated on Bayada policy 0-1237 and standard of practice for catheter management.	
G 121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>This STANDARD is not met as evidenced by: Based on record review and confirmed by staff interview, the HHA (Home Health Agency) failed to ensure that staff were in compliance with accepted professional standards and principles during the provision of care for 1 of 3 clients reviewed. (Client #1) Findings include:</p> <p>1. Per record review, staff failed to follow professional standards of practice regarding catheter insertion and assessment of wounds. Client #1 was admitted with a Foley catheter and had doctor orders to change the catheter every 30 days or as needed (PRN). Additionally the Client also had two wounds that were to be monitored and dressed. Per a concern brought to the attention of the HHA, Client #1 "felt uncomfortable" during the insertion of the catheter and alleged that the nurse inserted a gloved finger in a private part. Per interview on 08/11/14 at 11:10 AM the nurse stated that s/he explained the procedure to the client in which the gloved finger would be used "as a guide" for the Foley catheter insertion. The nurse further stated</p>	G 121	<p>To ensure newly hired nursing staff is competent in catheter care and following Bayada policy 0-1237, CM or RN designee will conduct a field supervisory visit with new nursing hires to assess their competency in catheter care.</p> <p>To ensure compliance, CM or designee will conduct in-service on Bayada policy 0-1237, Catheterization and Management- Urinary Catheters. Home Health Director will monitor compliance monthly for 3 months and report findings to Administrator during Quarterly QA meetings.</p>	<p>7/17/14</p> <p>11-3-14</p> <p>11-3-14</p> <p>11-15-14</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/5/2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that proper 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 121 Continued From page 1
that " I done it this way for years and never had a complaint, I didn't mean to make the client feel uncomfortable". The nurse confirmed that this was not the standard of practice for catheter insertion.
In addition, per record review the nurse failed obtain wound measurements for each wound. The client had two large wounds that needed daily changing. Per review of the policy and procedure for wound care, states the wound(s) should be measured every week [in centimeters] and/or per physician's order. The client's wounds were not measured for nearly a two week period (06/23/14 - 07/11/14). Per interview on 08/12/14 at 11:40 AM the nurse stated that the expectation would be to measure the wounds every week as part of the assessment.
Per interview on 08/12/14 at 12:04 PM the Clinical Manager [for skilled services] confirmed nursing staff failed to follow accepted Professional standards and principles for care and services.

References:
Lippincott Manual of Nursing Practice 8th addition, page 10 and 724.
KCI V.A.C therapy, Clinical Guidelines- a reference source for clinicians, August 2010,

G 144 484.14(g) COORDINATION OF PATIENT SERVICES

The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.

G 121 The RN responsible for wound care for client #1 was re-educated regarding Bayada policy 0-3230, Wound Care Assessment and Treatment.

To ensure ongoing compliance, field clinicians will be provided an in service on wound care management by CM or designee at staff meeting.

The CM or designee will monitor compliance by completing chart audits for 10% of wound care cases for 3 months to ensure appropriate wound documentation.
Home Health Director will monitor compliance monthly for 3 months and report findings to Administrator during Quarterly QA meetings.

*Exc G-121 accepted 9/25/14
Cynthia J. Emmons RN*

11-3-14

11-3-14

11-13-14

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G 144	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview, the agency failed to assure the clinical record or case conference established effective reporting and coordination of client care and services occurred for one applicable client (Client #2) Findings include: 1. Per recrod review the nurse failed to assure the clinical record or case conference notes established effective reporting and/or coordinations of changes in Client #2's condition or needs. A nursing visit note dated 08/25/14 states "...PCP [primary care physician] also made aware upon medication reconciliation patient noted not to have Risperdal, Seroquel or Benzotropine in with meds in home states, I threw them out about 2 days ago...client states he told [the psychiatrist] and [the PCP]". Per interview on 08/12/14 at 3:30 PM the Branch Clinical Manager stated "[PCP] is very involved in the case and will even make home visits. The [psychiatrist] wrote the meds but [the office manager at the Health Center] is very good with following up." The Clinical Manager stated "I am assuming the PCP told the Psychiatrist. S/he confirmed there were no follow up notes from either physicians noted in the case conference notes. also see G-0176	G 144	The RN responsible for care coordination for client #2 spoke with the physician's representative to communicate changes in the Clients condition and noted in the clients record. Bayada staff received in-service regarding client documentation, care coordination, effective reporting and conditions of participation from Bayada Director of Home Health Regulatory and Quality Affairs. To ensure the clinical record accurately reflects action and follow-up, the CM or designee will in-service staff regarding Bayada policy 0-944, Client Care Coordination. The CM or designee will monitor compliance by reviewing coordination of care documentation by completing an audit of 10% of records for 3 months.	8-27-14
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.	G 176	Home Health Director will monitor compliance monthly for 3 months and report findings to Administrator during Quarterly QA meetings.	11-13-14

*POC G-144 corrected
9/25/14 Stan J. E. Mingo, FR*

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G 176	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and confirmed through interview, the RN failed to assure clinical and progress notes were accurate and failed to inform the physician of the client's needs for 2 of 3 Clients in sample (Clients #1 and #2) Findings include: 1. Per record review on 08/12/14 the nurse failed to notify the physician of issues that occurred during a Foley catheter change and that the plan of care was inaccurate for Client # 1. Per review of the record, the 485 (Physician order/plan of care] dated 06/20/14 - notes that the catheter is to be changed every 30 days or as needed with a 30 French . 5 cc Foley catheter. Per review of the nursing visit note of 06/28/14 shows Client #1 experienced some blood and leaking of the catheter. The nurse repositioned the catheter after removing the water from the balloon and instilled 30 cc of water. It furthers notes "the client felt urine coming around the catheter, the nurse checked and some moisture was found the nurse added 5 cc water into the balloon. Per interview at 11:40 AM on 08/12/14 the Registered Nurse (RN) stated the 30Fr 5 cc Foley catheter size was written incorrectly on the 485 and "what I remember is what was already in place was a 30FR 30 cc, when[the client] was leaking I took a 10 cc syringe and removed 30 cc but because I didn't have a 30 cc syringe I was not sure if a instilled 30 cc [3 x 10 cc] so I added a little more." The nurse at that time confirmed the doctor was not informed of the issues during care and services and the orders were transcribed incorrectly.	G 176	Bayada conducted investigating into the incident and found that the RN did not adhere to Bayada policy 0-1237 Catheterization and Management- Urinary Catheters. RN responsible for Catheter care to Client #1 was removed from the case, counseled, and re-educated on Bayada policy 0-1237 and standard of practice for catheter management. To ensure compliance, CM or designee will conduct in-service on Bayada policy 0-1237, Catheterization and Management- Urinary Catheters. To ensure the clinical record accurately reflects action and follow-up, the CM or designee will in-service staff regarding Bayada policy 0-944, Client Care Coordination. Home Health Director will monitor compliance monthly for 3 months and report findings to Administrator during Quarterly QA meetings.	7/17/14 11-3-14 11-13-14

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G 176 Continued From page 4
2. The nurse failed to inform the physician of changes in Client #2's condition or needs. Per a nursing visit note dated 06/25/14 states "...PCP [primary care physician] also made aware upon medication reconciliation patient noted not to have Risperdal, Seroquel or Benzotropine in with meds in home states, I threw them out about 2 days ago...client states he told [the psychiatrist] and [the PCP]".
Per interview on 08/12/14 at 3:30 PM the Branch Clinical Manager stated " [PCP] is very involved in the case and will even make home visits. The [psychiatrist] wrote the meds but [the office manager at the Health Center] that I spoke to on the phone and is very good with following up' ". The Clinical Manager stated "I am assuming the PCP told the Psychiatrist. S/he confirmed there were no follow up notes from either physicians. Per telephone interview on 08/13/14 at 12:02 P.M. the PCP stated "the first time I heard about it [not taking the medications] was at the office, when [Client #2] came in on the 26th and told me. I put a telephone call into [the psychiatrist],... I did let the psychiatrist know because [s/he] is the prescriber for those meds and would need to check if there were to be changes or something."
The PCP confirmed that s/he was not informed by the HHA.
also see G-0144

G 176 The RN responsible for care coordination for client #2 spoke with the physician's representative to communicate changes in the Clients condition and noted in the clients record.

To ensure the clinical record accurately reflects action and follow-up, the CM or designee will in-service staff regarding Bayada policy 0-944, Client Care Coordination.

The CM or designee will monitor compliance by reviewing coordination of care documentation by completing an audit of 10% of records for 3 months.
Home Health Director will monitor compliance monthly for 3 months and report findings to Administrator during Quarterly QA meetings.

11-3-14

11-13-14

11-13-14

POC G176 accepted
9/25/14
John J. Egan, RN