



VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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

March 19, 2013

Tracy Chellis, Administrator
Bayada Home Health Care
110 Kimball Avenue, Suite 250
So Burlington, VT 05403-6925

Provider ID #:477019

Dear Ms. Chellis:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 15, 2012**.

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

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota, RN".

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure



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

Licensing and
Protection

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 11/15/2012
NAME OF PROVIDER OR SUPPLIER BAYADA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 110 KIMBALL AVENUE, SUITE 250 SO. BURLINGTON, VT 05403	
(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		
G 176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, Agency staff failed to inform the physician of changes in the client's condition and needs for 1 client in the complaint sample. (Client # 1) Findings include:</p> <p>Per record review for Client # 1 on 10/31/12 the nurse case manager made a skilled nursing visit on 8/7/12 which included a weekly prepouring of medications into a pillbox. During that visit, s/he was informed by a family member that although the physician had ordered an antidepressant drug and that the filled prescription was in the home, s/he decided that because of its potential side effects, s/he did not want the medication given to Client # 1.</p> <p>This nurse, during an interview with the branch director on 8/17/12 stated that 's/he had called the physician to confirm the order for the antidepressant, however, had not 'heard back' from the physician.</p> <p>Per review of the nurse progress notes for that</p>	G 176	<p>The nurse who failed to pour a medication on the doctor's medication list or document her attempts to reach the doctor was counseled by Director Michael Nigro on August 21st. That nurse resigned September 20th and is not employed with BAYADA. On August 22nd, clinician's were trained on medication list management, communication with physicians, and proper documentation in Coordination of Service notes during their weekly meeting. Clinical Manager will ensure continued trainings occur on these topics and Director will ensure completion of POC.</p> <p><i>POC G-176 accepted on 3/18/13 Sus-D Evans RN</i></p>	12-14-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Marcy Chellis 11-30-12 Administrator

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012
FORM APPROVED
OMB NO. 0938-0391

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G 176	Continued From page 1 8/7/12 visit, there was no written documentation of this conversation and that she had attempted to notify the physician. The nurse left without filling the pillbox that week with the antidepressant. During the next skilled nursing visit, on 8/15/12, a different nurse made the skilled nursing visit. After finding the prescription bottle of the antidepressant with no physician orders in the clinical record, s/he called the Agency as well as the physician to report this. The physician verified the medication and the dosage so the nurse pre-poured the anti-depressant into the pill box per the MD order. Several days later, on 8/17/12 Client # 1's family member complained to the (branch) Director of the Agency that the pills had been 'mlspoured' and that the anti-depressant should not be in the pillbox. The Director also confirmed on 10/31/12 at 11:30 A.M. that there was no documentation that the first nurse (who visited on 8/7/12) had followed up with the physician regarding the antidepressant verbally or in written communication. The second nurse, who made the 8/17/12 skilled nursing visit, had poured the pills according to physician's orders.	G 176			
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the	G 236			

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G 236	<p>Continued From page 2 attending physician; and a discharge summary.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the clinical record failed to contain pertinent past and current findings in accordance with accepted professional standards for 1 client (Client # 1) in the complaint sample receiving home health services. Findings include:</p> <p>Per record review for Client # 1 on 10/31/12 the nurse case manager made a skilled nursing visit on 8/7/12 which included a weekly prepouring of medications into a pillbox. During that visit, s/he was informed by a family member that although the physician had ordered an antidepressant drug and that the filled prescription was in the home, s/he decided that because of its potential side effects, s/he did not want the medication given to Client # 1.</p> <p>This nurse, during an interview with the branch director on 8/17/12 stated that 's/he had called the physician to confirm the order for the antidepressant, however, had not 'heard back' from the physician.</p> <p>Per review of the nurse progress notes for that 8/7/12 visit, there was no written documentation of this conversation and that she had attempted to notify the physician. The nurse left without filling the pillbox that week with the antidepressant.</p> <p>During the next skilled nursing visit, on 8/15/12, a different nurse made the skilled nursing visit. After finding the prescription bottle of the antidepressant with no physician orders in the clinical record, s/he called the Agency as well as</p>	G 236	<p>The nurse who failed to pour a medication on the doctor's medication list or document her attempts to reach the doctor was counseled by Director Michael Nigro on August 21st. That nurse resigned September 20th and is not employed with BAYADA. On August 22nd, clinician's were trained on medication list management, communication with physicians, and proper documentation in Coordination of Service notes during their weekly meeting. Clinical Manager will ensure continued trainings occur on these topics and Director will ensure completion of POC.</p> <p>POC G-236 accepted 3/18/13 Susan D. Emmons RN</p>	12-14-12	

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G 236	Continued From page 3 the physician to report this. The physician verified the medication and the dosage so the nurse pre-poured the anti-depressant into the pill box per the MD order. Several days later, on 8/17/12 Client # 1's family member complained to the (branch) Director of the Agency that the pills had been 'mispoured' and that the anti-depressant should not be in the pillbox. The Director confirmed on 10/31/12 at 11:30 A.M. that there was no documentation in the clinical record that the first nurse (who visited on 8/7/12) had followed up with the physician regarding the antidepressant verbally or in any written communication. In addition, there was a failure to document the conversation with the family member that they had not wanted the antidepressant given to the patient.	G 236		