

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 28, 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 **February 27, 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
State Survey Agency Director

FK:jl

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

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

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 02/27/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BAYADA HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 80 PEARL STREET ESSEX JUNCTION, VT 05452
---	--

(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 An unannounced onsite investigation into complaints and self-reported incidents was conducted on 2/18-2/19/14, and concluded on 2/27/14. The following federal regulatory finding was identified.	G 000		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to develop a plan of care that included all pertinent information and diagnoses for 1 of 4 patients sampled (Patient #1). Findings include: Per record review on 2/18/14, Patient #1 was on the Choices for Care Program since August 27, 2013, receiving support from the agency to continue living at home, despite advancing dementia and noted safety concerns. The patient had two episodes of skilled services, one from September 5, 2013 to November 3, 2013, and the other starting on January 13, 2014 to March 13, 2014. The documentation in a Coordination of Services note from 11/1/13 stated that an LNA who was caring for Patient #1 called the office to	G 159	The clinical managers from the personal care and visit team will review all shared client records during the care coordination meetings. CM will review for evidence of care coordination between all disciplines as well as with external entities providing services for the client; weekly for 2 months for 100% compliance, then as required for client referral care coordination. 4/10/2014 Home Care Director will re-educate all Hourly Service Clinical Mangers and Client Services Managers on the use of policy 0-6768 - HOME HEALTH AIDE CARE PLAN SUPPLEMENT PRECAUTIONS, and 126 - HOME HEALTH AIDE CARE PLAN, and 37-107 MENTAL HEALTH EMERGENCY MANAGEMENT 4/10/2014. Clinical Manager will notify director of all mental health emergencies, and will show evidence of documentation in the clients chart. 4/10/2014 Skilled Visit Services Directors will re-train Clinical Managers in the use of the Point Care Visit Alert feature of the client's electronic medical record to ensure that information related to precautions is reviewed by the clinician prior to every visit. Clinical Manager will review shared clients records that have newly discovered precautions to ensure the point care visit alert is active and field clinician is aware. 4/10/2104 To ensure compliance the directors from the personal care and visit team will audit care coordination documentation for shared clients quarterly for 2 quarters for 100% compliance, then randomly thereafter. 4/10/2014	

G159 POC accepted 3/27/14 Karen Campos RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Celine D. Hill</i>	TITLE Administrator	(X6) DATE 3/21/2014
--	------------------------	------------------------

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

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

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 02/27/2014
NAME OF PROVIDER OR SUPPLIER BAYADA HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 80 PEARL STREET ESSEX JUNCTION, VT 05452		
(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 159	Continued From page 1 report that the patient had stated "When people lose their mind they should be able to end their life and that is what he is going to do when the time comes." The LNA was concerned because there was a gun in the home. The case manager from the home health agency called the physician, family members, and the Choices for Care case manager to alert them of the incident. Per further review of the documentation, on 1/9/14, Patient #1 told a home health aide that he would "kill himself tonight" since he had been "sad and scared" the night before. The case manager instructed the aide to stay with the client, and spoke with management team. The decision was made to call the police due to the possibility of there still being a firearm in the house. The police indicated they were on their way to the home, and the case manager instructed the aide to calmly leave the residence to assure their safety. The police informed the case manager that the client gave up the guns willingly but would not agree to be transported anywhere for treatment. Although the case manager stated that the aides going into the home were aware of the suicidal threat, there was no written update to the aide plan of care to indicate to staff what protocol to follow, and no specific precautions related to threat of self-harm. Also on the 485 Plan of Care initiated on 1/13/14 when the patient went back on skilled services, there was no mention of monitoring for suicidal ideation at nursing visits, and the plan of care only stated that the nurse was to assess the patient for generalized depression, and make a referral to provide counseling and assistance with managing depression. Per interview on 2/18/14 at 4:15 PM, the case manager confirmed that the 485 Plan of Care did not include any mention of the high risk	G 159			

POC accepted 3/27/14 Klampor

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

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

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 02/27/2014
NAME OF PROVIDER OR SUPPLIER BAYADA HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 80 PEARL STREET ESSEX JUNCTION, VT 05452		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 2 of self harm and need to assess specifically for this, and also that the home health aide plan of care did not include an alert that the patient was a suicide risk and direction for staff if Patient #1 was indicating self-harm.	G 159		