

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

February 10, 2015

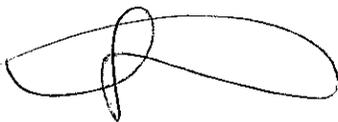
Ms.. Celine McGill,
Bayada Home Health Care
80 Pearl Street
Essex Junction, VT 05452-3668

Dear Ms.. McGill:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 6, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



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

SL:jl

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

PRINTED: 01/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 477018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/06/2015
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	G 000			
G 143	<p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interviews, the home health agency failed to coordinate services to provided assessed needs for 1 of 2 clients in the sample (Client # 2) The specifics are as follows:</p> <p>Per record review on 01/06/2015 at 1:18 PM, the home health agency failed to provide personal care services to Client # 2. Client # 2 was referred by his/ her physician for Physical Therapy (PT) and Occupational Therapy (OT) and admitted to services on 10/10/2014. No LNA services were ordered by the MD. The initial assessment indicates that s/he needed assistance in toileting, getting out of bed and other activities of daily living. Client had previously been a client of another home health agency closer geographically to his/ her home and had been receiving LNA (Licensed Nursing Assistant) services to assist with morning care that included cleaning client and getting him/her out of bed.</p>	G 143	<p>Bayada Home Health Care was able to hire appropriate LNA services for Client #2, per the request of the client's guardian.</p> <p>Bayada Home Health Care Director and/or Clinical Manager will review with all filed clinicians the coordination of patient services during the field staff meeting.</p> <p>Weekly the Clinical Manager will review all new clients care plan with the assigned clinicians to ensure appropriate coordination of care.</p> <p>The Director will establish additional service agreements with other community agencies, home care providers, and staffing agencies to ensure the appropriate services are provided.</p>	2/27/15 2/27/15 3/16/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X5) DATE *2/2/15*

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.

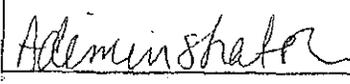
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 01/06/2015
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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
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G 143	Continued From page 1 During interview in the afternoon, the Clinical Director reports that they often share clients with other home health providers and were not aware that Client # 2 had been receiving LNA care prior to admission to this home health agency until the guardian called to request the addition of providers. The Clinical Director further stated that this client was not skilled. Client #2 was receiving skilled PT and OT during the initial certification (10/10/2014-12/08/2014) period. S/he could have had LNA services provided until other arrangements were made to have LNAs hired specifically for this client. Client # 2 was discharged from skilled PT services on 11/05/2014 and readmitted to Medicaid, unskilled services 12/30/2014 which included LNAs 5 times per week through the certification period ending 02/27/2015. S/he was seen for 3 visits by OT during December. Not until December was staff provided in the form of LNAs with nursing supervisory visits because other skilled services were out of the home and nursing was not a skilled need. This was confirmed by the Clinical Director.	G 143	The Director will continue to contact sister offices to provide available staff as needs arise. Interviews are being conducted to hire a Recruiting Manager to enhance recruitment efforts throughout the state. The Administrator will ensure compliance by a review of recruiting needs weekly with each Director for 2 months, then monthly for 2 months, and quarterly thereafter.	3/16/15 2/27/15
				2/2/15

*POC
2/2/15
S.D.*

Division of Licensing and Protection

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H 001	<p>Initial Comments</p> <p>An unannounced, on site investigation of a complaint and an agency self report was conducted on 01/06/2015 by the Division of Licensing and Protection. There were no state regulatory issues identified.</p>	H 001		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
TITLE
(X6) DATE

Celine M. Jiles

Administrator

1/30/15