

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

November 2, 2015

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

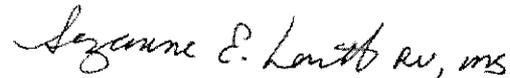
Dear Ms. McGill:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 29, 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,

Sincerely,



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



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

PRINTED: 10/02/2015
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 09/29/2015
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 An unannounced on site investigation for four Agency self reported incidents was conducted by the Division of Licensing and Protection on 09/28/15 - 09/29/15. The following Federal regulatory deficiencies were identified:	G 000	<i>accepted PO C</i> <i>G-141</i> <i>Snowden, Emmms RN 10/29/15</i>	
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by: Based on record review and staff interview the Agency failed to ensure that personnel practices are followed to meet regulatory requirements. The findings include;	G 141	After thorough review, research, and outreach to CMS' Boston Regional Office, we believe BAYADA has in fact met this STANDARD and would like the opportunity to further discuss this issue. After several years of operation under this model of parents and branches maintaining their own personnel records and making them available to surveyors upon request, thorough and ongoing research regarding this issue, as well as recent guidance received from the Regional Office's Certification & Enforcement Branch, Northeast Consortia Division of Survey & Certification ("RO"), we believe our approach is consistent with the goals of the COPs and that BAYADA is in compliance with such standard. A representative from the RO informed BAYADA that it is acceptable for a branch to store its own personnel records. We were advised that should the State or other entity decide to conduct a survey at the parent office, the parent office would be responsible for obtaining the necessary records from the branch; and likewise, if the	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES	G 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Celan McGee, Administrator* TITLE _____ (X6) DATE *10/22/15*

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.

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G 143	Continued From page 1 All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview staff failed to coordinate services for 1 of 4 applicable clients in the sample. (Client #4) Findings include: 1. Per record review on 9/29/15 for Client # 4, who has special needs that include occupational therapy (OT), a specialized community agency and social worker, the home health Agency staff did not communicate and/or coordinated the objectives as outlined in the care plan. Per telephone interview on 09/29/15 at 10:53 AM the Clinical Manager at the branch office stated, there was a meeting with the physician, client and client's family regarding a change to services, specifically a change to occupational services in the home and other special needs. There is no evidence as demonstrated by documentation that the occupational therapist and the specialized community agency and social worker were informed of what was discussed at this meeting. The Clinical Manager confirmed at 10:53 AM there is no evidence that the Agency maintain liaison between the OT, social worker and community resource.	G 143	surveyor were on location at a branch and asked to review personnel records from the parent office. We understand it is BAYADA's responsibility to ensure surveyors have access to all documentation necessary to complete their review in a timely manner and are committed to ensuring any and all records requested for review are promptly sent to the surveyors' attention. This is consistent with BAYADA's approach across 16 states and throughout all of its 75 Medicare certified offices, in which 40 of these offices operate within the parent/branch structure. The Administrator of each Medicare Provider Number, including the one at issue, maintains responsibility for ensuring the branches maintain personnel records in accordance with law, regulations, and policies of BAYADA. Upon request of a surveyor, any personnel record is made available within a few hours. G143 Coordination of Patient Services: The initial complaint from the client #4 had been addressed through a meeting held by the Branch Director, community resource agency, and the family, and had been resolved with no change to the OT services for the client.	9/16/15	
G 144	Also see G-144 484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange,	G 144	Documentation of care coordination meeting has been updated to include discussion with the Branch Director, occupational therapist, social worker, and community resource agency.	10/19/15	

Accepted for G-143
 10/29/15
 Emma R.

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G 144	Continued From page 2 reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on record reviews and staff interviews the agency failed to show in the clinical record case conferences were conducted to provide for effective reporting and coordination of client care for 1 of 4 Clients (#4) in the sample. Findings include: 1. Based on record review and staff interview, agency staff failed to consistently document that case conferences had occurred for Client #4 regarding special needs. Per record review there is no coordination notes between the Clinical Manager [CM] and other staff, community agency or social worker regarding the monthly on site visits. In addition, the branch office was made aware on 08/17/15 by family, of concerns with "poor communication between family and clinical manager". Per a telephone interview on 09/29/15 at 10:15 AM the CM at the branch office "remembers writing information [from a meeting with the physician and family in July or August 2015] but my lap top is not working". The Branch Director, who was present in the Main office, then instructed the CM to "go to another computer and fax us what you have". At 10:42 AM a 'draft' was sent that contained no date and time. There was information regarding specialists appointments, changes in health care providers and other programs. During the subsequent telephone call at 10:53 AM, the CM confirmed not all coordination notes were readily available, documented as well as the above noted 'draft letter' which was not reported	G 144	The Director of Clinical Operations (DCO) and Manager of Clinical Operations (MCO) will provide re-education to all Clinical Managers and Clinical Associates on Policy 0-944 Client Care Coordination. Specifics of the re-education will include: When service is provided through liaison with other organizations or individuals, coordination of services is maintained by the team effort of the Client Services and Clinical Managers, and the information is documented in the client chart. Communication from other sources, such as reports from the aides/field nurses and additional collateral contacts, must be documented in the client chart. Corrective action will also include implementation of a structured process for interdisciplinary conferences to review active clients, (2x/month) to assure actions and goals of services are complimentary and evaluated related to goal achievement. Monitoring: A 100% focus audit of active clients with external agency involvement will be conducted for 3 months by the DCO and MCO. Additionally 10% of active clients will be audited for 3 months to ensure compliance with appropriate care coordination. Results of audits will be reported to Administrator to monitor for ongoing compliance. 12/10/15 Sustained improvement and compliance will be monitored through quarterly record review by the Clinical	10/30/15

accepted POE
10/29/15
Shaw
Emmha RN

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G 206	Continued From page 5 supplement medication form that directs staff to follow a bowel regime requiring an enema every 3-4 days as needed. Per review of the three LNA/PCAs, who are the primary care givers, and documented that they provided enema care, only one staff was noted to have specific training for giving an enema. Per interview on 09/28/15 at 2:46 PM the Clinical Manager stated "They shouldn't do anything especially a skill like an enema without prior training". S/he confirmed that only one of the three staff had been instructed and demonstrated the specific skill for this client. 3. During the record review on 09/28/15 Client #3's care plan has special instructions for LNA/PCA staff to assist with self-administration of medications. Per review of the LNA/PCA's training records there is no evidence that this training was provided to the LNA/PCA staff. The Branch Director at 3:20 PM stated "we definitely need to look at how we demonstrate evaluations/competency of the PCA/LNAs, who give special care especially med administration. Clearly this is not happening with the staff that were reviewed".	G 206	The Clinical managers will supervise and document competency assessment. The branch director/designee is responsible to review all applicant information, including skills checklist to ensure appropriate assignment and matching of skills to the care plan, to include completion of HHA competencies, including demonstration before independent assignment. Compliance will be monitored monthly by the branch director/designee through record review of the employee files to assure competency completion before specific assignment. Results of the records review will be reported the Administrator to ensure ongoing compliance.	10/30/15 11/7/15	<i>accepted POC R-206</i>