

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 27, 2015

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

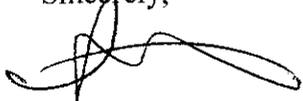
Provider ID #:477019

Dear Ms. McGill:

Enclosed please find a copy of your acceptable plans of correction for the State and Federal surveys conducted on **January 28, 2015**.

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

Sincerely,



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

Enclosure

FEB 13 2015

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

PRINTED: 02/02/2015
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 01/28/2015
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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 000	INITIAL COMMENTS	G 000		
G 102	<p>An unannounced onsite re-certification survey was conducted by the Division of Licensing and Protection 01/26/15 - 01/28/15. The following are Federal regulatory findings.</p> <p>484.10(a)(1) NOTICE OF RIGHTS</p> <p>The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the Home Health Agency (HHA) did not assure the patient was informed of the rights in a manner of his/her understanding. (Patient #1) Findings include:</p> <p>1. Patient #1 was identified as having another primary language during admission. The Patient Right's, written in English, was signed by Patient #1 who is alert and able to make her/his own decisions. The case manager's reports notes communication is relayed to [a child]. Per review of the HHA's policy on communication with persons with Limited English Proficiency (LEP) reveals that children and other clients will not be used to interpret in order to ensure confidentiality of information and accurate communication. It also notes that vital documentation, other written information and a notice of the availability for translation is free of charge for LEP individuals. During interview on 01/26/15 at 1:38 P.M. the Director of Home Care stated that a home visit would be difficult as the patient did not</p>	G 102	<p>To ensure that all current clients have been appropriately communicated their Notice of Rights, the Clinical Manager or designee will administer the Client Comment Form and the Agreement for Services in the clients' native language.</p> <p>All future admissions will be assessed for primary language, and the Client Comment Form and the Agreement for Services will be provided in client's native language. Client will be provided a notice of the availability for a translator or DPOA who can appropriately represent the client.</p>	<p>3-20-15</p> <p>3-20-15</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Cheryl Smith* TITLE *Administrator* (X6) DATE *2/16/15*

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 102	Continued From page 1 understand/speak English. When furthered questioned as how staff communicate with this patient, the Director of Home Care stated that staff will gesture, a care plan was written or the [child] could be contacted. The Director of Home Care confirmed at that time the patient wasn't informed of the rights in a manner of his/her understanding.	G 102	Bayada Home Health Care was able to hire appropriate LNA services for Client #3.		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on record review and interviews the agency failed to assure that patients are accepted based upon a reasonable expectation that the patient's needs can be met adequately in the place of residence for 1 of 20 patients(Patient #3). Findings include: Per record review the agency received a referral on 12/12/2014 for Skilled Nurses (SN), Physical Therapy (PT), Occupational Therapy (OT), and Home Health Aide services. The Start of Care date was 12/13/2014. SN, PT, and OT services began during the first week of service (December 15, 16, and 17, 2014 respectively). The Home Health Aide services did not begin approximately three weeks later on 01/07/2015. In an interview on 01/27/2015 at 10:20 AM the Associate Director confirmed that the client did not receive services until 01/07/2015. S/he	G 157	Weekly the Clinical Manager will review new clients care plan with the assigned clinicians to ensure appropriate coordination of care. The Director will establish service agreements with other community agencies, home care providers, staffing agencies, and contacting sister offices for shared staff to ensure the appropriate services are provided. 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.	2-27-15 2-27-15 3-16-15 2-27-15	

*Doc Control
2-25-15
S. Sam 102*

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G 157	Continued From page 2	G 157	Clinical Manager of Hi Tech Services will in service staff nurses on Bayada Home Health Care policy #'s 0-282 CONTROLLED SUBSTANCES ADMINISTRATION AND DISPOSAL, 0-990 MEDICATION MANAGEMENT AND ADMINISTRATION, and 758 NARCOTIC RECORD regarding documentation of Controlled substance counts. Completion of in-service will be documented in employees file, Controlled Substance in-service will be added to annual in-services for Hi Tech clinicians. To ensure that Controlled Substances are appropriately accounted, the Clinical Managers of Hi-Tech services will audit the submitted narcotic count sheets monthly; and the CM will conduct a review of narcotic count sheets during supervisory visits.	2-20-15	
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. This STANDARD is not met as evidenced by: Based on observation, record review and interview the HHA nurses' failed to follow the ordered plan of care and failed to provide acceptable medication practice for 1 applicable patient (patient # 4) Findings include: 1. Patient #4 was identified as a 'Hi-Tech' patient needing specialized nursing services. The 485 [physician order/plan of care] directs staff to check the ventilator settings, oxygen tanks, change circuit hoses and the filters every Mondays, as well as other care services. The patient also was prescribed a controlled substance(Vicodan) . Per observation on 01/26/15 between 4:30 PM and 5:15 PM the nurse did not clean the ventilator's filter nor verified the controlled substance's count. During interview at this time the nurse surveyor asked about the procedure for counting controlled substances and the changing of the filter. The staff nurse stated because the counts were off at times, the mother was storing the Vicodan. The medication sheet for the Vicodan had a notation that stated "gave one tablet to [a private care provider]". Per review of the medication record the Vicodan was not consistently counted nor counted since November 2014. The staff nurse	G 174			

Handwritten signature and date:
02/02/15
[Signature]

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G 174	Continued From page 3 further stated that they ran out of the circuit hose "so it was changed this past weekend [5 days late] but I don't know why [the other staff nurse] didn't change the filter". At the request of the nurse surveyor the staff nurse inspected the filter which was noted to be dust-filled and dirty. The nurse then changed the filter. Per interview on 01/28/15 at 9:40 AM the Clinical Manager stated that "the nurses were directed to do the counts on a regular basis". And the expectation is to follow the plan of care and to change the filter on a weekly basis. The Clinical Manager confirmed the nurse failed to follow the ordered plan of care and provide acceptable medication practice.	G 174	The Clinical Manager of High Tech services will educate the staff RN's on the appropriate procedures and documentation for equipment maintenance. Monthly, The CM of High tech services will audit the submitted equipment maintenance tracking log for accuracy. The CM will review the equipment maintenance log during supervisory visits.	2-20-15	
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on record review and interviews with agency staff, the agency failed to make the initial assessment visit within 48 hours of the referral date for 1 of 20 patients in the sample. (# 2). Findings include: 1. Per review on 01/27/15, Patient #2 was assessed and admitted on 08/19/14, five days after the referral. Per review of the the referral dated 08/14/14, the physician wrote for a physical therapy evaluation. There was no documentation that the patient was contacted prior to or requested the August 19th assessment for start of care. In addition, there was no evidence that the physician was notified that the admit date	G 332	The Director of Home Care Services or designee will add an annual in-service for appropriate process and documentation for narcotic count sheets and equipment maintenance logs. The Director will provide re-education to the office and field staff on timely and accurate documentation regarding client services. The Client Services Manager will document all interactions with clients regarding their scheduled visits.	3-20-15	3-20-15

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G 332	Continued From page 4 would be after the request date. Per interview on 01/27/15 at 3:59 PM the Director of Home Care stated "my guess is that the family probably requested the change [for start of service]". S/he confirmed at that time that there is no evidence that the patient was contacted and that the physician approved the patient's request for a delayed start of care.	G 332	To ensure on going compliance, the CSM will review all referrals and verify that the SOC is within the required time frame. The Director will monitor by auditing the timely initiation of care weekly for 1 month, than monthly thereafter.	3-20-15	

*Document
2-26-15*