VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line:(888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 22, 2019

Kristin Barnum, Administrator
Bayada Home Health Care
600 Blair Park Road, Suite 300
Williston, VT 05495-7589

Provider ID #:477019

Dear Ms. Barnum:

Enclosed is a copy of your acceptable plans of correction for the federal complaint investigation survey conducted on **October 22, 2019**.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	477019	A. BUILDING _____ B. WING _____	C 10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYADA HOME HEALTH CARE	600 BLAIR PARK ROAD, SUITE 300 WILLISTON, VT 05495

(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 complaint investigation was conducted on 10/21/19 - 10/22/19 by the Division of Licensing and Protection. The following Federal regulatory violations were identified: G 606 Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is not met as evidenced by: Based on staff interview and record review, the Home Health Agency (HHA) failed to assure there was effective and timely coordination of services between Agency staff and consistent exchange of patient care needs for the provision of care for 1 applicable patient. (Patient #1) Findings include: Patient #1 was admitted to the HHA on 9/17/18 for LNA (Licensed Nursing Assistance) for 3 hours twice weekly to assist with personal care needs via a Private Pay arrangement. However, Patient #1's care needs increased and additional LNA hours were provided by the HHA. In addition, Patient #1 demonstrated a decline in health and became illegible for Hospice services which were initiated 12/8/18. In combination of both benefits, Patient #1 continued to receive both LNA/PCA (Personal Care Assistance) services via HHA Private Pay program and Hospice benefit services to include Hospice nurse, Medical Social Worker and LNA services. Over the past 6 months Patient #1 demonstrated a decline in	G 000 G 606	G606 Based on an analysis of the specific deficiencies cited, the corrective plan and actions taken are to address the lack of demonstrated knowledge resulting in failure to ensure there was effective and timely coordination of services between Agency staff and consistent exchange of client care needs for the provision of care. The plan of correction will be completed through comprehensive focused education and re-instruction. Client #1 no longer receives services from this organization. By 11/30/2019, all office staff will be re-educated by the Division Director/designee on policy Client Care Coordination, 0-944, with emphasis was placed on maintaining a team effort in the coordination of services when services are provided with other organizations or individuals and documenting efforts of the coordination of care in the client chart including communication from other sources, such as reports from aides/field nurses and additional collateral contacts. Education also included a review of policy Incident Reporting and Documentation, 0-933 with emphasis on the procedures and timeframes to report an incident and adverse events and, when a client is shared, to ensure all involved teams are aware of the incident. Policy Fall Prevention Program 37-301 was reviewed with emphasis on following up with client, caregiver and possibly the employee to assess the situation and need for further evaluation including a reassessment of the client if needed to determine need for implementation of fall prevention interventions.	11/30/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristin Barnum RN, MBA	Administrator	11/18/2018

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 606	Continued From page 1 ability to feed himself/herself, reduction in appetite/concentration and became an increased fall risk due to periodic inability to consistently bear weight and cooperate with transfer from bed to wheelchair and/or bedside commode. Because of transfer concerns, per Coordination of Care Note dated 5/3/19 acknowledges Hospice staff considered Patient #1 as a 2 person assist with transfers. Because of input from family who considered Patient #1 to only require 1 person for transfers a home visit was made on 5/6/19 by the Brattleboro branch office nursing staff and Hospice staff to determine transfer options and needs for Patient #1. It was determined Patient #1 remained a 1 person assist with transfer to commode and/or wheelchair However, on 5/15/19 while transferring Patient #1 from bed to bedside commode, Patient #1 was unable to remain standing and with the assistance of the LNA, was guided to the floor. 911 was called for assistance by the LNA and upon arrival EMS staff assisted with returning Patient #1 back to bed. No injuries were reported and it was determined by EMS the patient did not require a transfer to an Emergency Department for evaluation to rule out injury. As per HHA policy 0-933 Incident Reporting and Documentation last revised 1/13/2018, " 2.2 Incidents defined as Adverse Events include but are not limited to: g. Any client fall when Bayada is present.....". The policy also states: "Client and employee incident documentation 3.1 Client Incidents. 3.1.1 "All incidents must be reported as outlined as soon as possible, but not more than 24 hours after learning of a potential incident. Incident supplements are submitted as new facts are learned or as investigation proceeds".	G 606	Effective 11/30/2019, cross collaboration meetings will be conducted weekly for all shared clients to ensure care plan is relevant and pertinent information is shared with all team members. Effective 12/1/2019 for three months, the Director/designee will review weekly 100% incident reports for completion within the required timeframe and communicated to all involved teams. Additionally, the Clinical Manager/designee will review weekly all new admissions identified as a fall risk to determine the appropriate care plan and interventions have been instituted. The expected compliance threshold will be 100%. Failure to achieve 100% will be addressed through focused education with the individual staff members by the Director/designee. Sustained improvement will be monitored through quarterly clinical record reviews conducted as a required component of the Organization's Quality Assurance and Performance Improvement program. The Director has overall responsibility for implementation and oversight of the plan. G: 606 POC Accepted. 11/21/19	

Kristin Barnum R, MBA Administrator 11/18/2019

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G 606	Continued From page 2 Per interview on 10/22/19 at 4:10 PM the LNA confirmed s/he had contacted the On-call manager on 5/15/19 regarding Patient #1's fall to the floor. Although Hospice staff were made aware of the fall on 5/15/19 , it was not until 7/12/19 when family reported the fall which occurred on 5/15/19, did the Brattleboro Branch office staff become aware of the fall incident. A coordinated investigation of the event and evaluation of Patient #1's care needs and services provided by the Brattleboro Branch office did not occur as per HHA policy. As result of failing to conduct required follow-up to the incident reported on 5/15/19, HHA staff failed to follow policy 37-301 Fall Prevention Program last revised 3/12/2018 which states 8.0 Fall Reporting and Follow-up Process, 8.1.2 "the clinical Manager or designate staff (Visit Nurse, Case Manager, therapist) will follow up with client, caregiver and possibly employee to assess the situation and need for further evaluation. This follow up, whether by telephone or home visit.....must occur as soon as possible but no later than one (1) week after notification of the fall." The HHA failed to follow their own process, to include an evaluation of potential safety risks associated with Patient #1's ability to assist with transfers and whether present equipment used was effective and safe. This failure to track and manage incident reporting and lack of communication and coordination of care was confirmed on 10/22/19 at 3:35 PM by the Director Home Health Care.	G 606		
G 654	Track adverse patient events CFR(s): 484.65(c)(2) Performance improvement activities must track	G 654		

Kristin Barnum RN, MBA Administrator 11/18/2019

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G 654	Continued From page 3 adverse patient events, analyze their causes, and implement preventive actions. This STANDARD is not met as evidenced by: Based on staff interview and record review there was a failure of the HHA's staff to follow the Agency's Quality Assurance/Performance Improvement (QA/PI) program to effectively evaluate, fully analyze and fully implement immediate actions when an adverse patient event occurred. (Patient #1) Findings include: On 5/15/19 while transferring Patient #1 from bed to bedside commode, Patient #1 was unable to remain standing and with the assistance of the LNA, was guided to the floor. 911 was called for assistance by the LNA and upon arrival EMS staff assisted with returning Patient #1 back into bed. No injuries were reported and it was determined by EMS the patient did not require a transfer to an Emergency Department for evaluation to rule out injury. As per HHA policy 0-933 Incident Reporting and Documentation last revised 1/13/2018, " 2.2 Incidents defined as Adverse Events include but are not limited to: g. Any client fall when Bayada is present.....". The policy also states: "Client and employee incident documentation 3.1 Client Incidents. 3.1.1 "All incidents must be reported as outlined as soon as possible, but not more than 24 hours after learning of a potential incident. Incident supplements are submitted as new facts are learned or as investigation proceeds". Per interview on 10/22/19 at 4:10 PM the LNA confirmed s/he had contacted the On-call manager on 5/15/19 regarding Patient #1's fall to the floor. A Client Occurrence Report was completed on 5/15/19 and Hospice staff were made aware of the fall. However, it was not until	G 654	G654 Based on an analysis of the specific deficiencies cited, the corrective plan and actions taken are to address the lack of demonstrated knowledge resulting in failure to fully analyze and implement immediate actions when an adverse client event occurs. The plan of correction will be completed through comprehensive focused education and re- instruction. Client #1 no longer receives services from this organization. By 11/30/2019, all office staff will be re-educated by the Division Director/designee on policy Client Care Coordination, 0-944, with emphasis was placed on maintaining a team effort in the coordination of services when services are provided with other organizations or individuals and documenting efforts of the coordination of care in the client chart including communication from other sources, such as reports from aides/ field nurses and additional collateral contacts. Education also included a review of policy Incident Reporting and Documentation, 0-933 with emphasis on the procedures and timeframes to report an incident and adverse events and, when a client is shared, to ensure all involved teams are aware of the incident. Policy Fall Prevention Program 37-301 was reviewed with emphasis on following up with client, caregiver and possibly the employee to assess the situation and need for further evaluation including a reassessment of the client if needed to determine need for implementation of fall prevention interventions. Additionally, education included a review of policy 0-403 - QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM with emphasis on tracking	11/30/2019

Kristin Barnum RN, MBA Administrator 11/18/2019

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G 654	Continued From page 4 7/12/19 when family reported the 5/15/19 fall did the Brattleboro Branch office staff become aware of the fall incident. A coordinated investigation of the event and evaluation of Patient #1's care needs and on-going LNA services provided by the Brattleboro Branch did not occur between Hospice and the Branch home care service staff. As result of failing to conduct required follow-up to the incident reported on 5/15/19, HHA staff failed to follow policy 37-301 Fall Prevention Program last revised 3/12/2018 which states: 8.0 Fall Reporting and Follow-up Process, 8.1.2 "the clinical Manager or designate staff (Visit Nurse, Case Manager, therapist) will follow up with client, caregiver and possibly employee to assess the situation and need for further evaluation. This follow up, whether by telephone or home visit.....must occur as soon as possible but no later than one (1) week after notification of the fall." The HHA staff failed to follow Agency process, to include an evaluation of potential safety risks associated with Patient #1's ability to assist with transfers. This failure to track and manage incident reporting and lack of communication and coordination of care was confirmed on 10/22/19 at 3:35 PM by the Director Home Health Care. The missed opportunity to effectively evaluate the incident involving Patient #1, through the utilization of Agency QA/PI review processes and incorporation of opportunities for improvement did not occur.	G 654	and managing incident reporting and identified trends to determine opportunities for improvement. Effective 11/30/2019, cross collaboration meetings will be conducted weekly for all shared clients to ensure care plan is relevant and pertinent information is shared with all team members. Effective 12/1/2019 for three months, the Director/designee will review weekly 100% incident reports for completion within the required timeframe and to ensure the incident was communicated to all involved teams. Additionally, the Director/designee will identify trends quarterly and initiate practice changes based on data analysis. The expected compliance threshold will be 100%. Failure to achieve 100% will be addressed through focused education with the individual staff members by the Director/designee. Sustained improvement will be monitored through quarterly clinical record reviews conducted as a required component of the Organization's Quality Assurance and Performance Improvement program. The Director has overall responsibility for implementation and oversight of the plan. P.O.C. Accepted G.654 11/20/19	

Kristin Barnum RN, MBA Administrator 11/18/2019