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

May 29, 2018

Kristin Barnum, Director
Bayada Hospice
316 Main Street Unit Eh-6
Norwich, VT 05055-4428

Provider ID #:471510

Dear Ms. Barnum:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 4, 2018**.

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

Sincerely,

Suzanne E. Leavitt RN, MS

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
	471510	A. BUILDING _____ B. WING _____	C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYADA HOSPICE	316 MAIN STREET UNIT EH-6 NORWICH, VT 05055

(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
L 000	INITIAL COMMENTS An unannounced, on-site complaint investigation was conducted by the Division of Licensing and Protection from 4/2 - 4/4/18, as authorized by the Centers for Medicare and Medicaid Services to determine compliance with the Conditions of Participation 418.52 Patient Rights, 418.54 Initial and Comprehensive Assessment of the Patient, 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services, 418.58 Quality Assessment and Performance Improvement, and 418.104 Clinical Records. As a result, the following regulatory violations were identified associated with complaint #16459.	L 000		
L 512	RIGHTS OF THE PATIENT CFR(s): 418.52(c)(1) The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness; This STANDARD is not met as evidenced by: Based on record review, family and staff interview, the agency failed to ensure effective pain management and symptom control for conditions related to terminal illness for 1 of 9 patients sampled (Patient #1). Findings include: Per record review, Patient #1 was admitted to Hospice Services on 12/8/17 wit a terminal cancer diagnosis. Patient #1 had significant pain associated with this condition, and the physician ordered Hydromorphone extended release 32 mg. tablet by mouth twice daily, and Hydromorphone 8 mg. two tablets by mouth every	L 512	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 effective pain management and symptom control for conditions related to terminal illness. The plan of correction will be completed through comprehensive focused education and re- instruction. The staff member providing care to this patient was re-educated by the Director Clinical Operations on 4/5/2018 on agency policies: 0-4588 - ADMISSION BOOKLET - HOSPICE SERVICES (which addresses Patient Rights related to Pain Management), 0-1353 - PAIN MANAGEMENT FOR CLIENTS, CAREGIVERS AND FAMILIES, 0-886 - PAIN ASSESSMENT AND MANAGEMENT, and 0-4568 - CLIENT ASSESSMENT - HOSPICE SERVICES. Emphasis on continuous assessment/evaluation of patient response, appropriateness of route of administration, and consulting with physician/IDG team to assure pain management medications are providing relief to the patient.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kristin Barnum RN MBA

TITLE
VT Administrator Hospice Div Director

(X6) DATE
5/14/2018

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L 512	Continued From page 1 3 hours PRN (as needed). On 12/19/17, the physician added another 8 mg tablet to the PRN order so the patient was able to take 24 mg. orally every 3 hours for pain management. According to the family, the patient was taking up to 136 mg. of Hydromorphone daily to control pain. There was also a bottle of injectable Morphine in the home comfort kit that was prescribed to treat severe pain in the event of a bowel obstruction, which had not been utilized by the patient. Per review of the nurse's notes and information provided in a family interview, Patient #1 had expressed a preference to not have rectal suppositories as a medication delivery route. The patient was able to swallow the pills effectively up until the last couple days of life. On 12/20/17, the nurse documented that the family had tried crushing the medication mixed with water to administer it, however the patient was having swallowing issues and gagging on the oral meds. The nurse called around to local pharmacies to locate a liquid Hydromorphone suspension, and was not able to find any nearby. The Hospice Pharmacy was contacted, and the liquid Hydromorphone was shipped to the patient's home for a next day delivery. In the interim, the patient's pain was being managed by inserting Hydromorphone tablets in the rectum for absorption, as this was the only medication delivery route that was available to manage the patient's pain. Although there was a bottle of injectable Morphine in the home, there were no syringes available to inject the medication, so that was unavailable to use. Patient #1 died at approximately 5:00 AM on 12/21/17 before the liquid medication arrived at the home. Per interview, the family reported that they did not feel that there was adequate pain management during the hours leading to the patient's death, and that	L 512	On 4/5/2018 the Director Clinical Operations re-educated all Clinical Managers, and members of the Psychosocial Team on agency policies: 0-4588 - ADMISSION BOOKLET - HOSPICE SERVICES (which addresses Patient Rights related to Pain Management), 0-1353 - PAIN MANAGEMENT FOR CLIENTS, CAREGIVERS AND FAMILIES, 0-886 - PAIN ASSESSMENT AND MANAGEMENT, and 0-4568 - CLIENT ASSESSMENT - HOSPICE SERVICES. Emphasis on continuous assessment/evaluation of patient preference, response, appropriateness of route of administration, and consulting with physician/IDG team to assure pain management medications are providing relief to the patient. Effective 5/14/2018 for three months and until 100% compliance is achieved, the Director/designee will review bi weekly the electronic record of all patients with Pain Management as an identified problem on the care plan for documentation of patient preference,efficacy of pain medications, consultation with physician/IDG team when current pain medications are not relieving the patients pain. Director/designee will audit client records Bi-weekly during the IDG meeting with documentation in minutes kept in the Quality Assurance/Performance Improvement Binder, then monthly until 100 percent compliance and then quarterly with documentation for one year in minutes kept in the Quality Assurance/Performance Improvement Binder. If during the record review any discrepancies are found, corrections will be made and the employee responsible will be counseled. Sustained improvement and compliance will be monitored through record review inclusive of regular reviews conducted by organizational Quality Assurance audits. Acceptable 5-17-18 KC/SL	

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L 512	Continued From page 2 the rectal suppository of tablets did not provide a large enough dose to address the symptoms and provide relief to the patient, and that they had not wanted to utilize the rectal suppository route. The family stated that the Hospice did not anticipate ahead of time the patient's needs for effective pain medication that could be given by alternative routes when the patient was no longer able to swallow. Per interview on 4/3/18, the Director of Hospice confirmed that Patient #1 did not receive adequate pain and symptom management in a manner that was the preference of the patient, when the oral route was no longer an option.	L 512		
L 533	UPDATE OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(d) The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. This STANDARD is not met as evidenced by: Based on record review and staff interview, the Hospice agency failed to ensure that the Interdisciplinary Group evaluated and updated the initial patient assessment at least every 15 days for 3 of 9 patients reviewed (Patient's #1, #5, and #9). Findings include:	L 533	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 that the Interdisciplinary Group evaluated and updated the initial patient assessment at least every 15 days. The plan of correction will be completed through comprehensive focused education and re-instruction. Patient # 1 Patient deceased Patient # 5 Patient Admitted 7/14/2017 (IDG discussed and documented patient on 8/8/2017. Patient died 11/13/2017. Patient # 9 Patient admitted 10/13/17 (IDG discussed patient on 10/27/2017 but physician sign off of discussion was 10/31/2017 which exceeded the 15 day requirement. Patient discharge 3/9/2018. On 4/6/2018 the clinical managers were re-educated by the Division Director on their role/responsibility in on agency policy 0-4568 - CLIENT ASSESSMENT - HOSPICE SERVICES with emphasis on requirement for IDG to reassess patient response to care no less then every 15 days. POC amnt 5-17-18 KC/KL	

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L 533	Continued From page 3 1. Per record review, Patient #1 was admitted to Hospice on 12/8/17. The Interdisciplinary Group (IDG) was consulted soon after the nurse completed the comprehensive admission assessment as documented in the record. Per further review, the IDG team did not discuss Patient #1 at the 12/12/17 or the 12/19/17 meeting, and this does not meet the every 15 day requirement. The patient died on 12/21/17, and the first discussion at the IDG meetings occurred after their death on 12/26/17. Per interview on 4/3/18, the Director of Hospice confirmed that Patient #1 was not discussed by the team at either of these IDG meetings, and that Patient#1 had somehow been missed when adding newly admitted patients to the meeting schedule for discussion. 2. Per record review, Patient #5 was admitted to Hospice on 7/14/17. The first IDG meeting after admission where this patient was discussed by the team occurred on 8/8/17, 24 days after the start of care. The Hospice Director confirmed that the patient was not discussed at the IDG meeting every 15 days as required. 3. Per record review, Patient #9 was admitted with a start of care date of 10/13/17. The IDG meeting notes show that the patient was not discussed at the 10/17/17 IDG meeting, but was put on the schedule and discussed at the 10/31/17 IDG meeting, which was 18 days after the patient was admitted. Per interview, the Director of Hospice confirmed that the frequency of discussion of this case did not meet the every 15 day regulatory requirement.	L 533	On 4/6/2018 the division director re-educated directors to increase awareness of identifying patients for discussion /review at scheduled IDG meetings including the requirement that the hospice IDG reassesses the client's response to care as often as required by the client's condition. A review of the documentation process in the electronic system including acknowledgement of all participants was included in the education. On 4/9/2018 the Director Clinical Operations re-educated all field disciplines on agency policy, 0-4568 - CLIENT ASSESSMENT - HOSPICE SERVICES with emphasis on requirement for IDG to reassess patient response to care no less then every 15 days. A review of the documentation process in the electronic system including acknowledgement of all participants was included in the education. Effective 5/14/2018 for three months and until 100% compliance is achieved, the Director/designee will review weekly the electronic record of all new admissions/current patients for the schedule of patient discussion with the IDG members within the 15 day requirement. Director will audit client records weekly with documentation in minutes kept in the Quality Assurance/Performance Improvement Binder, then monthly until 100 percent compliance and then quarterly with documentation for one year in minutes kept in the Quality Assurance/Performance Improvement Binder. If during the record review any discrepancies are found, corrections will be made and the employee responsible will be counseled. Sustained improvement and compliance will be monitored through record review inclusive of regular reviews conducted by organizational Quality Assurance audits.	
L 537	IDG, CARE PLANNING, COORDINATION OF SERVICES	L 537	Based on an analysis of the specific deficiencies cited, the corrective plan and actions taken are to	

Accept 5/17/18 KC/K

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L 537	Continued From page 4 CFR(s): 418.56 The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that the input of all Interdisciplinary Group team members was documented as being involved in preparing the written plan of care for 2 of 9 patients sampled. (Patients #4, #7). Findings include: 1. Per record review, Patient #4 was admitted to Hospice on 12/5/17. The initial comprehensive assessment completed by the Registered Nurse documented that the Medical Director and the attending physician were notified and consulted regarding the plan of care development for Patient #4. There was no documented evidence that the Social Worker or the Spiritual Counselor were consulted for their input into the plan of care. 2. Per record review, Patient #7 was admitted with a start of care date of 1/3/18. The Registered Nurse completed the initial comprehensive assessment, however only documented the involvement of the Case Manager and the Social Worker. There was no evidence that the entire Interdisciplinary Group had participated in developing the plan of care for Patient # 7. Per interview on 4/4/18 at 10:05 AM, the Director of Hospice confirmed that there was no documentation that the entire IDG team was	L 537	address the lack of demonstrated knowledge resulting in failure to ensure the initial plan of care was developed with participation of the members of the interdisciplinary group (IDG). The plan of correction will be completed through comprehensive focused education and re- instruction. Patient # 4 (Social work visited on 12/8/2017, Spiritual Counselor documented 12/8 spoke with family spiritual needs met no visits required) Patient # 7 (Social work visited on 1/5/2017 Spiritual counselor documented on 1/5 spoke with family no visits needed wanted spiritual needs met. All IDG members reviewed care plan 1/16, 1/30) On 4/6/2018 all Clinical Managers, Psychosocial Managers and Directors were re-educated by the Division Director on their role/responsibility in participating and preparing the written plan of care On 4/11/2018, the Director re-educated all Interdisciplinary Group staff on policy 0-4538 - INTERDISCIPLINARY GROUP and 0-4556 - CARE PLAN - HOSPICE SERVICES emphasizing the roles and responsibilities of the IDG members in the development of the client's care plan. Education also included the process for documentation utilizing the electronic client record to identify the members of the IDG who were contacted regarding the client's admission and documenting their participation in the development of the client's care plan. The electronic documentation system was updated so that the care plan review function cannot be bypassed. Effective 5/14/2018 for three months and until 100% compliance is achieved, the Director/designee will review weekly the electronic record of all new admissions for the presence of the IDG members who were contacted upon client admission and who participated in the development of the clients care plan. Director designee will audit client records weekly with documentation in minutes kept in the Quality	

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L 537	Continued From page 5 involved in the development of the plan of care for Patients #4 and #7.	L 537	Assurance/Performance Improvement Binder for 3 months until 100% compliance, then monthly 5 charts until 100 percent compliance and then quarterly 5 charts with documentation for one year in minutes kept in the Quality Assurance/Performance Improvement Binder. If during the record review any discrepancies are found, corrections will be made and the employee responsible will be counseled. Sustained improvement and compliance will be monitored through record review inclusive of regular reviews conducted by organizational Quality Assurance audits.	
L 552	REVIEW OF THE PLAN OF CARE CFR(s): 418.56(d) The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that the hospice Interdisciplinary Group reviewed the plan of care, and revised if necessary, at the required 15 day frequency for 3 of 9 patients reviewed (Patients # 1, #5, and #9) Findings include: 1. Per record review, Patient #1 was admitted to Hospice on 12/8/17. The Interdisciplinary Group (IDG) was consulted and contributed to the plan of care soon after the nurse completed the comprehensive admission assessment. Per further review, the IDG team did not discuss Patient #1 at the 12/12/17 or the 12/19/17 meeting, and this does not meet the every 15 day requirement to review and possibly revise the plan of care. The patient died on 12/21/17, and the first discussion at the IDG meetings occurred after their death on 12/26/17. Per interview on 4/3/18, the Director of Hospice confirmed that Patient #1 was not discussed by the team to review the plan of care at either of these IDG meetings, and that Patient#1 had somehow been missed when adding newly admitted patients to	L 552	L552 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 that the Interdisciplinary Group reviewed the plan of care and revised as necessary at the required 15 day frequency. The plan of correction will be completed through comprehensive focused education and re- instruction. Patient # 1 Patient deceased Patient # 5 Patient Admitted 7/14/2017 (IDG discussed and documented patient on 8/8/2017. Patient died 11/13/2017. Patient # 9 Patient admitted 10/13/17 (IDG discussed initial patient assessment/care plan review on 10/27/2017 but physician signoff of discussion was 10/31/2017 which exceeded the 15 day requirement. Patient was discharged on 3/9/2018. On 2/6/2018 the clinical managers were re-educated by the Division Director on their role/responsibility on agency policy 0-4568 - CLIENT ASSESSMENT - HOSPICE SERVICES with emphasis on requirement for IDG to reassess patient response to care no less then every 15 days and 0-4556 - CARE PLAN - HOSPICE SERVICES Rec'd 5-17-18 KC/RL	

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L 552	Continued From page 6 the meeting schedule for discussion. 2. Per record review, Patient #5 was admitted to Hospice on 7/14/17. The first IDG meeting after admission where this patient was discussed by the team occurred on 8/8/17, 24 days after the start of care. The Hospice Director confirmed that the patient was not discussed at the IDG meeting every 15 days as required to review and possibly revise the plan of care. 3. Per record review, Patient #9 was admitted with a start of care date of 10/13/17. The IDG meeting notes show that the patient's plan of care was not reviewed at the 10/17/17 IDG meeting, but was put on the schedule and discussed at the 10/31/17 IDG meeting, which was 18 days after the patient was admitted. Per interview, the Director of Hospice confirmed that the frequency of discussion of this caseand review of the plan of care did not meet the every 15 day regulatory requirement.	L 552	with emphasis on plan of care is reviewed at a minimum of every 15 days including documentation requirements., 4/6/2018 the division director re-educated directors to increase awareness of identifying patients for discussion /review at scheduled IDG meetings including the requirement that the hospice IDG reassesses the client's response to care as often as required by the client's condition. A review of the documentation process in the electronic system including acknowledgement of all participants was included in the education. On 4/9/2018 the Director Clinical Operations re-educated all field disciplines on agency policy 0-4568 - CLIENT ASSESSMENT - HOSPICE SERVICES with emphasis on requirement for IDG to reassess patient response to care no less then every 15 days and 0-4556 - CARE PLAN - HOSPICE SERVICES with emphasis on plan of care is reviewed at a minimum of every 15 days including documentation requirements., Effective 5/14/2018 for three months and until 100% compliance is achieved, the Director/designee will review weekly the electronic record of all new admissions/current patients for the schedule of patient care plan review with the IDG members within the 15 day requirement. Director will audit client records weekly with documentation in minutes kept in the Quality Assurance/Performance Improvement Binder, then monthly until 100 percent compliance and then quarterly with documentation for one year in minutes kept in the Quality Assurance/Performance Improvement Binder. If during the record review any discrepancies are found, corrections will be made and the employee responsible will be counseled. Sustained improvement and compliance will be monitored through record review inclusive of regular reviews conducted by organizational Quality Assurance audits. Accept 5/17/18 KC/SL	

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