VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 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

April 19, 2023

Mr. Benjamin Goodwin, Manager
72 North Winooski Avenue Program
72 North Winooski Avenue
Burlington, VT 05401

Dear Mr. Goodwin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 23, 2023.** 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,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0505	A. BUILDING: _____ B. WING _____	C 01/23/2023

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72 NORTH WINOOSKI AVENUE PROGRAM	72 NORTH WINOOSKI AVENUE BURLINGTON, VT 05401

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T 001	Initial Comments On 1/18/23 the Division of LIcensing and Protection conducted an unannounced on-site relicensure survey and investigation of one complaint, with additional documentation received and reviewed on 1/23/23. The following regulatory deficiencies related to the relicensure survey and complaint investigation were identified:	T 001		
T 023 SS=F	V. 5.5.a Resident Care and Services 5.5 General Care 5.5.a Upon a resident's admission to a therapeutic community residence, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. The home's manager shall provide every resident with the personal care and supervision appropriate to his or her individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to provide care and supervision to residents, related to lack of staff accessibility and monitoring. Findings include: Per staff interview on 1/18/23 the facility is single staffed during the evening and overnight shifts. Overnight staff are permitted to sleep between the hours of 11 PM and 7 AM in a staff bedroom located within the facility office area. The office and staff bedroom are not connected to the residence by an interior doorway. Due to the lack of an interior doorway between the residence and	T 023	**See Attached**	

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T 023	Continued From page 1	T 023		

the staff office, residents must exit the facility and walk outside across a porch to knock on the locked office door when staff assistance is needed. When asked how residents can seek staff help in case of emergency or need of assistance during the overnight shift, staff stated the overnight staff sleeps with a cell phone placed near the bedside, and residents can knock on the office door for assistance. Seven out of eight facility residents live on the second floor of the home, and there is no telephone with emergency numbers located on the second floor of the home. The absence of a telephone and emergency numbers on the second floor impedes resident access to overnight staff in case of emergency and when in need of assistance. Please also refer to citation at T0188.

At approximately 10:30 AM on the morning of 1/18/23 the Manager confirmed the facility is single staffed during the evening and overnight shifts beginning at 5 PM daily and extending until as late as 8:00 to 9:00 AM. The Manager stated staff are instructed to spend time in the home, however when asked how s/he ensures staff accessibility and supervision of residents during periods of single staffing considering the separation of the office and sleeping area from the home s/he stated, " I know they are not in there". While staff stated they were confident they would hear a resident knocking on the office door if they were sleeping in the staff bedroom, at 11:33 AM a resident was observed by two surveyors knocking on the locked office door without response indicating the resident's knock was not heard by the Manager seated at the desk with his/her back to the door, and the Registered Nurse seated across the office from the door.

At 5:15 PM on 1/18/23 staff was asked to

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T 023	Continued From page 2 describe the evening workflow and routine. Staff responded most staff are checking the home about every 30 minutes and stated during training s/he was "primarily instructed to stay in the office instead of the house due to Covid". While it is important to note day staff were observed to be present in the home and engaged in care and supervision of residents, there were 2-3 staff on duty during the day shift which allowed for one staff to be in the home while another was working in the office. During periods of single staffing it is inevitable the home is unsupervised when staff is in the office due to the separation of the home and the office.	T 023		
T 036 SS=E	V.5.8.b Resident Care and Services 5.8 Medication Management 5.8.b The manager of the residence is responsible for ensuring that all medications are handled according to the residence's policies and that designated staff are fully trained in the policies and procedures. The manager shall assure that all medications and drugs are used only as prescribed by the resident's physician, properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all medications are properly labeled. Findings include: 1. Resident #2's Lantus Insulin Pen (for Diabetes management) was stored without a label	T 036	**See Attached**	

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T 036	Continued From page 3 indicating Resident #2's name and instructions for use on the Pen; and Resident #3's Basaglar Insulin Pen (for Diabetes management) was stored without a label indicating the Resident's name and instructions for use. At 11:45 AM on 1/18/23 the Registered Nurse confirmed Resident #2 and Resident #3's insulin pens were not properly labeled 2. Two large tablets stored in an uncovered plastic cup were observed in the medication cabinet without a label indicating the resident's name, medication name, instructions for use, and expiration date. On the afternoon of 1/18/23 the Manager confirmed the two tablets stored in an uncovered unlabeled medication cup were not properly labeled.	T 036		
T 038 SS=F	V.5.8.d.1.2.3.i.ii.iii.iv. Resident Care and Services 5.8 Medication Management d) If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment of the resident's care needs consistent with the physician's or other health care provider ' s diagnosis and orders. (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents. (3) The registered nurse must accept responsibility for the proper administration of	T 038	**See Attached**	

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T 038	Continued From page 4 medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure all unlicensed staff responsible for administering and dispensing medications to residents of the home have been trained and delegated to administer specific medications to specific residents by the Registered Nurse. Findings include: Based on review of medication delegation training documentation the Registered Nurse had not completed medication delegation training and observation for 11 out of 19 staff (Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) on the list of current employees provided by the	T 038		

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T 038	Continued From page 5 Manager of the home on the morning of 1/18/23. All staff at the home administer and dispense medications to residents of the home as part of their job duties. During an interview commencing at 12:13 PM on 1/18/23 the Registered Nurse confirmed there was no documentation of medication delegation training and observation completed for 11 staff who administer and dispense medications to residents of the home. This is a repeat citation.	T 038		
T 040 SS=E	V.5.8.5 Resident Care and Services 5.8 Medication Management 5.8.5 Staff other than a nurse may administer PRN psychoactive medications only when the residence has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Registered Nurse failed to develop a written plan for the use of PRN (as needed) psychoactive medication for 2 applicable residents (Residents #1 and #2). Findings include:	T 040	**See Attached**	

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T 040	Continued From page 6 Per record review Resident #1 is prescribed Risperidone (antipsychotic) 2 mg tablet One (1) table by mouth once daily as needed for voices (auditory hallucinations); and Resident # 4 is prescribed Lorazepam 1 mg tablet One (1) tablet every 4 hours as needed for panic level anxiety, not to exceed 2 tablets in 24 hours. At 12:35 PM on 1/18/23 the Registered Nurse confirmed a written plan had not been developed for the use of the psychoactive medications Risperidone for Resident #1 and Lorazepam for Resident #4 describing the specific behaviors the medications are intended to address; the circumstances that indicate the use of the medications; and educates the staff about the desired effects and undesired side effects of the medications.	T 040		
T 046 SS=F	V. 5.8.h.1 Resident Care and Services 5.8 Medication Management 5.8.h.1 Resident medications that the residence manages must be stored in double-locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure only authorized personnel have access to the medication cabinet keys. Findings include: At 10:26 AM on 1/18/23 the Manager confirmed there are three sets of keys all including a key to the medication cabinet, the responsibility for	T 046	**See Attached**	

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T 046	Continued From page 7 passing medications is shared by all staff on duty for each shift, and the medication cabinet keys are stored in a small lock box mounted on the wall beside the office door. The lock box door was observed to be left open throughout the duration of the survey, and was confirmed by the Manager to customarily remain open. While the office doors are locked, the practice of leaving the lock box open and storing multiple sets of medication cabinet keys in the open lock box permits access to the medication cabinet keys to anyone who enters the office.	T 046		
T 049 SS=E	V.5.8.h.4 Resident Care and Services 5.8 Medication Management 5.8.h.4 Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the residence ' s policy and applicable standards of practice and regulations. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to dispose of outdated medications. Findings include: The following expired and discontinued medications were observed in the medication storage area: 1. Resident #2's Trulicity 1.5 mg / 0.5 ml Injection Pen (for Diabetes management) was stored in the Medication refrigerator labeled "DO NOT USE". Due to an order change on 12/6/23 the use of this pen was discontinued. At 11:45 AM on 1/18/23 the Registered Nurse confirmed this	T 049	**See Attached**	

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T 049	Continued From page 8 mediation was not promptly disposed. . 2. Expired house stock medications observed in the medication cabinet included cough drops that expired on 9/11/22, and Diphenhydramine (Benadryl) 25 mg tablets that expired 8/31/22. The Manager confirmed expired the cough drops and Diphenhydramine 25 mg tablets were stored in the medication cabinet on the afternoon of 1/18/23. The Manager was requested to dispose of the expired house stock medications, however several hours after this request was made the medications were observed placed on a shelf and accessible in another area of the office.	T 049		
T 052 SS=F	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;	T 052	**See Attached**	

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T 052	Continued From page 9 (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure 5 out of 5 sampled staff completed all required yearly trainings. Findings include : Per review of staff training records, and confirmed by the Manager on the afternoon of 1/18/23, there was a failure to ensure 5 out of 5 sampled staff completed all required yearly trainings. Staff #3 and Staff #10 did not complete required yearly trainings including Fire Safety and Emergency Response; and Resident Emergency Response Procedures including First Aid. Staff #12 did not complete required yearly trainings including Fire Safety and Emergency Response, Resident Emergency Response Procedures including First Aid; and Mandatory Reporting of Abuse, Neglect, and Exploitation. Staff #13 and Staff #14 did not complete required yearly trainings including Resident's Rights; and Fire Safety and Emergency Response; and Resident Emergency Response Procedures	T 052		

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T 052	Continued From page 10 including First Aid.	T 052		
T 062 SS=D	V.5.10.b.4 Resident Care and Services 5.10 Records/Reports 5.10.b.4 The results of the criminal record and abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the results of employee criminal and abuse background checks are maintained on site and/or readily available for review on request; and to ensure written documentation stating the decision to hire 1 direct service staff (Staff #6) with a criminal conviction does not pose a threat to residents. Findings include: On the morning of 1/18/23 the Nurse Surveyors requested documentation of criminal and abuse background requests for a sample of 5 Staff. The Manager confirmed the background checks requested were maintained by the Human Resources Department of the organization that manages the home (Howard Center) and not available on-site for review. The Human Resources Department initially denied Surveyors access to the requested documentation, and required repeat requests to provide access to the background checks for review. On review of the background check documentation, Staff #6 had a conviction record of Driving Under the Influence in 2002, which was reported to the Human Resource Department by the Vermont Criminal Information Center in	T 062	**See Attached**	

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T 062	Continued From page 11 December of 2011. On the afternoon of 1/18/23 the Manager confirmed the personnel file for Staff #6 did not contain written evidence the decision to hire the employee did not pose a threat to residents of the home. This is a repeat citation.	T 062		
T 092 SS=E	VI.6.8 Residents Rights VI. Residents Rights 6.8 A resident may file a complaint or voice a grievance without interference, coercion or reprisal. Each residence shall establish an accessible written grievance procedure for resolving residents ' concerns or complaints that is explained to residents at the time of admission and posted in a prominent, public place on each floor of the residence. The grievance procedure shall include at a minimum, time frames, a process for responding to residents in writing within ten (10) days, and a method by which each resident filing a complaint or grievance will be made aware of the designated Vermont protection and advocacy organization as an alternative or in addition to the residence's grievance mechanism. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure the posted grievance policy outlined time frames including a process for responding to residents in writing within ten (10) days; and to respond to a resident's verbal complaint. Findings include:	T 092	**See Attached**	

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T 092	Continued From page 12 During the facility tour commencing at approximately 9:30 AM on 1/18/23 the facility Grievance Policy posted on the first floor of the residence was observed and confirmed by the Manager to be missing the times frames for responding to resident grievances within 10 days. Additionally, on the afternoon of 1/18/23 the Manager confirmed receipt of a verbal complaint by a former resident regarding the square footage of the resident's double occupancy room not meeting the regulatory requirement of 100 square feet per each bed, and stated a written response was not provided to the former resident in response to the complaint.	T 092		
T 146 SS=F	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interveiw there was a failure to provide and maintain a safe, functional, sanitary, homelike, and comfortable environment. Findings include: During the course of the facility tour commencing at approximately 9:30 AM on 1/18/23 the	T 146	**See Attached**	

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T 146	Continued From page 13 following environmental concerns were observed and confirmed by the Manager: * The door of the janitorial closet on the first floor of the home was observed to be open leaving Greenwave Bathroom Cleaner, Mega Shower Foamer, Windex, an open box of dishwasher detergent pods, an uncovered plastic tub of strong smelling disinfetant solution, and a bucket of cleaning solution on the floor accessible to residents. At 11:45 AM the closet remained open and accessible to residents, and Staff stated "it stays open all the time". At 12:00 PM on 1/18/23 the Manager of the home confirmed the janitorial closet customarily remains open leaving cleaning chemicals accessible to residents. This is a repeat citation. * A shared resident bathroom on the second floor of the home was observed with water and used paper towels on the floor. Used toothbrushes belonging to different residents were placed side by side and accessible to all residents on a shelf in the bathroom cabinet in need of cleaning, which is risk for exposure to infectous pathogens. During the facility tour the Manager stated the residents are responsible for cleaning the bathroom, and staff is responsible for cleaning the bathroom if a resident has not completed this task by 11 AM each morning. The bathroom was obseved to remain uncleaned at 11:55 AM on 1/18/23, which was confirmed by the Manager at 12:00 PM on 1/18/23. * On the second floor of the home flooring transitions from the hallway to resident rooms were observed to be missing threshold floor moulding. The unfinished thresholds left uneven flooring ends exposed with significant gaps between the flooring in the hall and the flooring in	T 146		

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	0505	A. BUILDING: _____ B. WING _____	C 01/23/2023

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T 146	Continued From page 14 the bedrooms, creating a trip hazard and potential splintering. During the tour of the second floor the Manager stated the flooring was installed in 2019; and stated a work order "ticket" request to repair the issue submitted to the organization that manages the facility had not resulted in completion of repairs. * In the pantry adjacent to the dining room 13 opened boxes of cereal were observed to be without labels indicating the dates they were opened; and a bag of flour and 2 bags of rice were observed stored directly on the floor. In the kitchen refrigerator opened perishable items including various condiments, sauces,and beverages were observed without dates; and an unlabeled butter dish containing a partial stick of butter was observed to be stored on the counter of a kitchenette adjacent to the kitchen.	T 146		
T 150 SS=D	IX.9.2.a Physical Plant 9.2 Residents ' Rooms 9.2.a Each bedroom shall provide a minimum of 100 square feet per bed. This REQUIREMENT is not met as evidenced by: Based on staff interview there was a failure to ensure a double occupancy resident room in the home meets the regulatory requirement for the required square footage of 100 square feet per bed. Findings include: On the afternoon of 1/18/23 the Manager confirmed Room 35 A&B does not the regulatory	T 150	**See Attached**	

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T 150	Continued From page 15 requirement of 100 square feet per bed. The Manager stated the room was measured in response to a verbal complaint by a previous resident and determined to be approximately 15 square feet less than the required square footage for a double occupancy room. The Manager stated s/he was unaware of any variances or waivers from the Licensing Agency allowing double occupancy of the room, and acknowledged accurate measurement of the room was not possible on 1/18/23 due to the amount to clutter in the room preventing access.	T 150		
T 187 SS=E	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.c Each residence shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to rotate times of fire drills to include drills conducted during the morning, afternoon, evening , and night; and to document the names of staff members participating in fire	T 187	**See Attached**	

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T 187	Continued From page 16 drills. Findings include: Per record review of the 12 months prior to the survey, fire drills were not conducted during the evening and night, and fire drill documentation forms did not include the names of staff members who participated in the drills. On the morning of 1/18/23 the Manager confirmed drills were not conducted in the evening and night, and the names of staff who participated in drills during the previous 12 months were not included in the drill documentation. This is a repeat citation.	T 187		
T 188 SS=E	IX.9.11.d Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the residence, at all times. A list of emergency telephone numbers shall be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to provide an operable telephone on each floor of the residence with a list of emergency telephone numbers posted beside each telephone. Findings include: Per observation during the facility tour commencing at approximately 9:30 AM on 1/18/23 a list of emergency numbers was not posted beside the telephone on the first floor of the residence, and there was no telephone or emergency numbers posted on the second floor	T 188	**See Attached**	

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T 188	Continued From page 17 of the residence. The Manager confirmed this observation during the course of the tour on the morning of 1/18/23 and stated the organization that manages the residence had determined the cost of providing a telephone on the second floor was too high. Per staff interview facility overnight staff are permitted to sleep between the hours of 11 PM and 7 AM in a staff bedroom located within the facility office area. When asked how residents can seek help in case of emergency or need of assistance during the overnight shift, staff stated the overnight staff sleeps with a cell phone placed near the bedside, and residents can knock on the office door to assistance. The office and staff bedroom are not connected to the residence by an interior doorway. Due to the lack of an interior doorway between the residence and the staff office, residents must exit the facility and walk outside across a porch to knock on the locked office door or call staff.. Seven out of eight facility resident's live on the second floor of the home. The absence of a telephone and emergency numbers on the second floor impedes resident access to overnight staff in case of emergency and when in need of assistance. This is a repeat citation.	T 188		
T999 SS=F	Final Comments This REQUIREMENT is not met as evidenced by: 4.4 Re-application (a) Application forms will be mailed to the applicant approximately sixty (60) days before the end of the licensing year. The completed application form must be returned to	T999	**See Attached**	

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T999	Continued From page 18 the licensing agency not less than forty-five (45) days before the expiration date. Upon receipt of a properly completed application, a license will be renewed assuming all other conditions for licensure are met. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview there was a failure to ensure the licensing reapplication process was completed within 45 days before the expiration date. Findings include: During the facility tour commencing at approximately 9:30 AM on 1/18/23 the posted license was noted to be expired. The most recent license issued to the facility expired on 11/30/2022. The Manager reported the reapplication process had been completed and the facility was awaiting a response from the Licensing Agency, however on further review the reapplication process had not been completed and the Manager had not responded to attempts on the part of the Licensing Agency to contact the Manager regarding the expired license. --- --- --- 4.12.b Whenever the authority is vested in the governing board of a firm, partnership, corporation, company, association or joint stock association, there shall be appointed a duly authorized qualified manager, however named,	T999		

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T999	Continued From page 19 who will be in charge of the daily management and business affairs of the residence, who shall be fully authorized and empowered to carry out the provisions of these regulations, and who shall be charged with the responsibility of doing so. The manager of the residence shall be present in the residence an average of twenty-two (22) hours per week. The twenty-two (22) hours shall include time providing services, such as transporting, or attendance at educational seminars. Vacations and sick time shall be taken into account for the twenty-two (22) hour requirement. In the event of extended absences, a qualified interim manager must be appointed. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview there is a failure to ensure the Manager of the Residence is present in the home an average of 22 hours per week. Findings include: On entrance to the facility at 9:15 AM on 1/18/23 two staff members greeted surveyors and identified the licensee on record as the Manager of the home and the person in charge. When asked if the Manager was on site and when s/he is scheduled to be at the home, staff stated the Manager is at the home "on Tuesdays and as needed". During the course of the survey additional staff indicated the Manager is at the home on Tuesdays and is otherwise available as needed. When asked his/her schedule during the entrance interview on the morning of 1/18/23 the Manager stated s/he is at the home 24 hours weekly and is at the home on Tuesdays, Thursdays, and Fridays. When informed this information was not	T999		

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T999	Continued From page 20 consistent with his/her schedule reported by staff, the Manager stated another facility s/he manages requires more of his/her time. On the morning of 1/18/23 the Manager confirmed s/he manages two facilities and is scheduled to work 37.5 hours weekly. This is a repeat citation.	T999		

Pamela M. Cota, RN
Licensing Chief
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 054671-2306

April 13, 2023

Dear Ms. Cota:

Listed below is the revised plan of correction for each deficiency cited in the re-licensing survey and complaint investigation at 72 N. Winooski Ave TCR of Howard Center, that took place on January 23, 2023. Revisions are based of the review of previously submitted plan of correction dated February 27, 2023.

V.5.5.a Resident Care and Services

T023 – 5.5a General Care
Action Taken – Facilities installed doorbells on the outside of the staff office area and on the 2nd floor to allow residents another method of alerting staff. Emergency phone numbers were posted on the second floor as well. There have been no incidents where staff have not been able to attend to client care needs during the overnight. Per section 5.9 of the TCR regulations there is sufficient staffing to provide necessary care, to maintain a safe and healthy environment, and to ensure prompt, appropriate action in case of injury, illness , fire or other emergences for the current residents within the facility and therefore we will not be making changes to the staffing structure at this time.

(Updated 4-13-23)
Cordless Handset installed on 2nd floor

Measures put in place to ensure the deficiency does not recur – Residents were instructed and educated on how to operate the doorbells and encouraged to use them to alert staff when they need assistance and staff are not within the main building.

(Updated 4-13-23) Cordless Handset installed on 2nd floor

Monitoring – Staff will continue to submit incident reports for clinical, or medical incidents that occur during the overnights. Staff will continue to educate and support residents to utilize the doorbell.
Completion – This was completed on 2/22/23 **(Updated 4-13-23) Cordless Handset installed on 2nd floor**
Tag T023 POC accepted on 4/19/23 by J. Evans/P. Cota
V.5.8.b Resident Care and Services

T036 – 5.8b Medication Management
Action Taken – 1. On 2/21/23 RN labeled both insulins pens with the resident names and instructions for use.
2. The unlabeled large tablets were disposed of while surveyors were on the property.

Measures put in place to ensure the deficiency does not recur – 1. Staff will add the pharmacy label to all insulin pens upon receipt of new insulin pens.
2. Staff will dispose of all poured and unused medication immediately and document on the disposal log.

Monitoring – RN will periodically review resident medications for required labeling to ensure that all labeling is correct and contains the necessary information. RN will review with staff at medication delegation training the proper way to ensure that all medications are properly labelled.

Completion – Completed on 2/21/23
Tag T036 POC accepted on 4/19/23 by J. Evans/P. Cota
V.5.8.d.1.2.3.i.ii.iii.iv. Resident Care and Services

T038- 5.8.d Medication Management
Action taken- RN completed delegation for employees 1,2 ,6,7 on 1/20/23. Upon review of the employee list, employees 9 and 10 had not worked in the program in the previous six months and were removed from the staff roster. Employees 3, 4, 8, and 11 will be delegated by 3/1/23.

Measures put in place to ensure that deficiency does not recur- RN will keep a schedule of annual delegations for each staff and will promptly train new hired staff.

Monitoring- Completed delegation forms will be kept in a binder in the staff office for review.

Completion- This will be completed on 3/1/23

Tag T038 POC accepted on 4/19/23 by J. Evans/P. Cota

V.5.8.5 Resident Care and Services

T040—5.8.5 Medication Management
Action Taken – On 2/21/23 RN updated resident orders to include resident specific indications for the use of psychotropic medications. Effects and side effects educational materials were added to the resident's records.

Measures put in place to ensure the deficiency does not recur – RN will update resident orders upon addition of new psychotropic medications, and educational materials will be provided to staff.

Monitoring – RN will review resident orders for required information periodically.

Completion – This was completed on 2/21/23
Tag T040 POC accepted on 4/19/23 by J. Evans/P. Cota
V.5.8.h.1 Resident Care and Services

T046- 5.8.h.1 Medication management
Action taken- During the duration of the survey all the keys within the lock box where in the possession of staff and were not left unlocked within the lock box. Moving forward if there are keys within the lock box that access the medication cart, then the lock box will be locked during that time.

Measures put in place to ensure the deficiency does not recur- Staff will ensure that they keep the lock box secure when there are keys still in the box. If they notice that keys are in the box and it is not locked they will promptly lock the box.

Monitoring- Manager will do periodic checks of the lock box.

Completion- This was completed on 2/21/23.

Tag T046 POC accepted on 4/19/23 by J. Evans/P. Cota

V.5.8.h.4 Resident Care and Services

T049—5.8.h.4 Medication Management
Action Taken – 1. RN disposed of Trulicity pen on 1/18/23 while surveyors were onsite. Staff were educated on how to dispose of insulin pens on 2/21/23.
2. The expired OTC PRN were disposed of on 1/18/23 while surveyors were onsite.

Measures put in place to ensure the deficiency does not recur – Staff will dispose of discontinued/expired medications including insulin pens monthly. Disposal will be tracked on a disposal log. When a resident death occurs, or a resident is discharged any left over medications will be disposed of immediately.

Monitoring – RN will periodically survey resident medications for discontinued, expired, and/or unlabeled medications. RN added checking for and discarding expired/discontinued medications to the monthly OTC PRN ordering checklist.

Completion – This was completed on 2/21/23
Tag T049 POC accepted on 4/19/23 by J. Evans/P. Cota
V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services

T052—5.9 Staff Services
Action Taken – Regular Staff were instructed to complete the required trainings on their next scheduled shift. Substitute staff were taken off the schedule until required trainings are complete. This process was implemented on 2/16/23.

Measures put in place to ensure the deficiency does not recur – The Manager will audit staff training records monthly to ensure compliance with required training. The Manager will schedule quarterly staff meetings for staff to complete due or upcoming required training.

Monitoring – The Manager will audit staff training records on the last Tuesday of the month and ensure staff are in compliance with required training.

Completion – All staff trainings will be in compliance by 2/28/23
Tag T052 POC accepted on 4/19/23 by J. Evans/P. Cota

V.5.10.b.4 Resident Care and Services

T062—5.10.b.4 Records/Reports
Action Taken – **(Updated 4-13-2023) Records are made available upon request from Howard Center Human Resources department. Records cannot be stored on Facility property per Agency policy. Agency policy is stated below.**

116. ACCESS TO AND DISCLOSURE OF HOWARD CENTER EMPLOYEE RECORDS
116.1 Electronic and Paper Personnel Records
Personnel data is maintained by the Human Resources Department and is the property of Howard Center. Personnel data (paper or electronic) is confidential. The Agency's Human Resources Department has immediate access to these records and other senior leaders may be given access on a need-to-know basis.
The following materials are commonly found in Howard Center personnel files: Personnel Action Form(s), correspondence (or copies) with prospective employee, application for employment, references, hiring letter, job description, Photo ID, change memo(s), record of registration, license, or degree (when applicable), orientation checklist, confidentiality statement, probation evaluations, performance reviews, copies of letters from insurance carriers, written termination notice, termination checklist, exit interview form, memoranda of performance issues, agreements with the employee, copies of employment references completed for outside requests, record of conference and workshop attendance, and other pertinent material.
Howard Center data and records related to Agency employees are segmented such that these items are maintained separately and are not part of personnel files: criminal record check documents and information, I-9 forms, Human Resources employee medical files (see Policy 119, below), complaint investigation files, any working file related to an employee that a manager or supervisor may keep for work-related purposes, and documents related to any judicial proceeding, law enforcement or state or federal agency investigation or administrative process.

Howard Center increasingly utilizes a human resource information system, or HRIS, which is a computer database used to gather, store, maintain and retrieve relevant employee personnel and HR-related information. This HRIS system is safeguarded under the Agency's proprietary electronic transmission and intranet policies and security

An Agency manager or supervisor (other than the employee in question) who has a clear work-related need to review a personnel file must make a request for review with the Sr. Director of Human Resources. In some situations, information from the personnel file may be provided rather than access to the file itself.

To address the issue of staff member #6, the Manager has completed a written statement including the employees name, criminal offense and why the facility has determined that this employee does not poses foreseeable risk to residents. This will be stored in the residential binder with variance approvals and requests.

Measures put in place to ensure the deficiency does not recur – **(updated 4-13-23) we will continue to have all background checks available upon request at any time. We will ensure the if any employee in the future has a background check that has findings we will completed the required documentation per the memo dated 2015. That documentation will be stored in the residential binder under the variance section.**

Monitoring – Howard Center completes comprehensive background checks on all new hires and randomly on current employees. Variance paperwork is kept on file for employees hired with discrepancies in their criminal/DMV records. These records are maintained in our Human Resources department. If we move forward with a hire that has discrepancies we will complete paperwork per memo 2015 and store in the residential binder.

Completion – This has been completed

Tag T062 POC accepted on 4/19/23 by J. Evans/P. Cota

VI.6.8 Resident Rights

T092—6.8 Resident Rights

Action Taken – On 2/21/23 the complaint process that is located on the first floor of the residence was updated to include timeframes for responding to resident grievances or

complaints. The verbal complaint that was reported by a previous resident cannot be addressed with that resident since they no longer reside at the facility.

Measures put in place to ensure the deficiency does not recur – The updated process has been posted in the resident areas and discussed in a community meeting with residents on 2/21/23.

Monitoring – The complaint process will be reviewed annually with residents and staff to ensure continued compliance. All complaints and grievances will be responded to within the outlined timeframe.

Completion – This has been completed.

Tag T092 POC accepted on 4/19/23 by J. Evans/P. Cota

IX.9.1.a Physical Plant

T146—9.1 Environment

Action Taken – 1. The janitor closet is now closed and locked at all times. Staff were reminded of the need to ensure that the janitor closet is locked at all times.
2. Residents were provided with sealable travel case for their toothbrushes on 1/31/23 and were instructed to keep their toothbrush in their person room.
3.Staff were delayed in cleaning the bathroom till after 12pm because they were occupied correcting other deficiencies the surveyors had identified. The bathroom was cleaned on 1/18/23.
4.**(updated 4-13-23) The flooring on the second floor will again be reviewed by Howard Center facilities to determine if any other measures can be put in place to reduce potential safety risks or tripping. Upon review on 2/21/23 it was deemed to not be a tripping hazard but we will review again and hire a contractor for repair should it be necessary.**
5. Staff labeled or discarded the opened pantry/refrigerator items on 1/18/23 while surveyors were onsite. The bags of rice and flour were being held on a 3-inch pallet, which surveyors stated was not far enough off the floor, but the items were not stored 'directly on the floor' as stated in the survey results. The items were moved onto shelves and the pallet discarded.

Measures put in place to ensure the deficiency does not recur – Signage was added to the janitor closet reminding staff that it should remain locked at all times. Residents were

provided with additional personal hygiene products to promote health and safety**. (Updated 4-13-23) Facilities will return and provide additional solutions to repair the floor.**

Monitoring – Staff will check common spaces in resident bathrooms twice weekly for personal items and return or discard if needed. The Manager will spot check the fridge/pantry for unlabeled items weekly.
Floor condition will be monitored regularly and reviewed by HUD and facilities.
(Updated 4-13-23)

Completion – All steps have been completed except flooring repair. **Flooring evaluation to determine repairs needed will be completed by May 1, 2023.**
Tag T146 POC accepted on 4/19/23 by J. Evans/P. Cota
IX.9.2.a Physical Plant

T150—9.2 Residents' Rooms

Action Taken –The licensee has attached a variance request for this deficiency.

Measures put in place to ensure the deficiency does not recur – Licensee will wait for a response from licensing regarding the variance request.

Monitoring – N/A

Completion – Variance request is attached to this report.

Tag T150 POC accepted on 4/19/23 by J. Evans/P. Cota

IX.9.11.c Physical Plant

T187—9.11 Disaster and Emergency Preparedness

Action Taken – The Manager updated the Monthly Safety Checklist to include a space to record staff names who conduct/participate in fire drills. The Manager updated the Monthly Safety Checklist to include quarterly evening/overnight checks. The next overnight check is scheduled for March 2023.

Measures put in place to ensure the deficiency does not recur – The Manager updated forms and guidance for staff to follow as of 2/16/23.

Monitoring – Manager will monitor Monthly Safety checklists upon completion to ensure the fire drills are being done during evenings/overnights.

Completion – Completed 2/16/23
Tag T187 POC accepted on 4/19/23 by J. Evans/P. Cota
IX.9.11.d Physical Plant

T188—9.11 Disaster and Emergency Preparedness

Action Taken – A list of emergency numbers has been posted by the resident phone on the first floor. Facilities installed a doorbell on the 2nd floor to allow residents to notify staff of an emergency. Emergency phone numbers were posted on the second floor for residents.
(updated 4-13-23) Cordless Handset installed on 2nd floor

Measures put in place to ensure the deficiency does not recur – Facilities installed a doorbell outside the staff office area and on the 2nd floor for residents to notify staff of an emergency from the 2nd floor. **(Updated 4-13-23) Cordless Handset installed on 2nd floor**

Monitoring – Use of the doorbell or alarm system will be tracked to gauge efficacy and use.

Completion – Completed 2/22/23 **(Updated 4-13-23) Cordless Handset installed on 2nd floor**

Tag T188 POC accepted on 4/19/23 by J. Evans/P. Cota

T999—Final Comments
Action Taken – 4.4 License application was submitted with all required documentation.
4.12.b **(updated 4-13-23) Only one Manager will be assigned per site to allow the Manager to be onsite for 22 hours a week. A different Manager will be listed and on site at the other location**

Measures put in place to ensure the deficiency does not recur – 4.4 the Manager will ensure that future re-applications are submitted no less than 45 days prior to the expiration date of the current license.

4.12.b **(updated 4-13-23) The Manager listed on the License will be on location for 22 hours a week minimum. A new Manager will be identified and listed for the other location and on site for 22 hours a week.**

Monitoring – 4.4 The Manager will note in their work calendar 50 days prior to when the re-application is due to ensure that the application is submitted on time.
4.12.b **(Updated 4-13-23) Manager will ensure that they keep their scheduled posted for their onsite time for 22 hours a week.**

Completion – Completed

Tag T999 POC accepted on 4/19/23 by J. Evans/P. Cota

Please reach out if you have any additional questions.

Sincerely,

Ben Goodwin, Senior Manager
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