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

January 29, 2019

Ms. Erin Daigle, Manager
Pennington House
1822 North Ave
Burlington, VT 05408-1303

Dear Ms. Daigle:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 7, 2019.** 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
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
	0607	A. BUILDING _____ B. WING _____	C 01/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON HOUSE	1822 NORTH AVE BURLINGTON, VT 05408

(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) COMPLETE DATE
R100	Initial Comments: An unannounced on site anonymous complaint investigation was conducted by the Division of Licensing and Protection on 1/7/19. The following regulatory violations were identified:	R100	Please see attached plans of correction.	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview, the facility nurse failed to ensure that 2 of 3 applicable residents reviewed, had updated care plans identifying the management of falls that occurred while being transported in/out of the shower stall located on the male hall. The findings include the following: 1. Per review of the Incident Report dated 8/4/18 at 6:30 AM, Resident #1 was being transported in a shower chair into the shower stall. As the wheels of the chair approached the uneven surface between the transition from floor to the shower, the chair tipped over and the resident fell to the floor hitting his/her right elbow and head. The resident sustained abrasions to the right elbows and knee. Per review of the care plan, the last update by the Registered Nurse was on	R145		

R145 - R266 POCs accepted 1/28/19 MBertrand RN/PMC

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R145	Continued From page 1 4/2/18. 2. Per review of the Incident Report dated 10/23/18 at 7 AM, Resident #1 was being transported in a shower chair into the shower stall. As the wheels of the chair approached the uneven surface between the transition from floor to the shower, the chair tipped over and the resident fell to the floor hitting his/her right elbow and head. The resident sustained abrasions of the right elbow. This is identified as the second fall for Resident #1, that occurred in the shower, but the care plan was not updated/revised to prevent further incidents. 3. Per review of the Incident Report dated 10/27/18 at 7 AM, Resident #2 was being transported out the shower stall using the shower chair. As the wheels of the chair approached the uneven surface between the transition from shower to the floor, the chair tipped over onto its right side with the resident landing on the floor. The resident hit the left side of his/her head and left knee that resulted in abrasions. Per review of the care plan, the last update by the Registered Nurse was on 4/2/18. Confirmation was made by the House Manager on 1/7/19 during the investigation, that there is no identification on the care plans for both Resident #1 and Resident #2, identifying falls nor does the plan direct staff the management of residents during transportation over the uneven surfaces in/out of the shower stall.	R145		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment	R266		

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R266	Continued From page 2	R266		

9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff interview the home failed to ensure that 1 of 2 bathing units (male area) is free from accident hazards to prevent falls for 2 of 3 applicable residents while being transported in/out of the shower stall. The facility also failed to ensure that the shower area was clean and failed to maintain 1 of 6 resident bureau's draws with necessary knobs. The missing knobs left sharp screws exposed, creating a hazard for Resident #2. The findings include the following:

1. Per review of the Incident Report dated 8/4/18 at 6:30 AM, Resident #1 was being transported in a shower chair into the shower stall. As the wheels of the chair approached the uneven surface between the floor to the shower, the chair tipped over. The resident fell to the floor onto his/her right side, while remaining in the chair. The resident sustained abrasions to the right elbows and knee.

2. Per review of the Incident Report dated 10/23/18 at 7 AM, Resident #1 was being transported in a shower chair into the shower stall. As the wheels of the chair approached the uneven surface between the floor to the shower, the chair tipped over. The resident fell to the floor hitting his/her right elbow and head. The resident sustained abrasions of the right elbow. Documentation on the incident report confirms that staff identify the new shower chair used for

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R266	Continued From page 3	R266		

transporting is a factor as it is lighter and feels different in use than the older heavier chair. The floor is also an ongoing factor due to the bump.

This was the second fall for Resident #1 related to the floor hazard.

3. Per review of the Incident Report dated 10/27/18 at 7 AM, Resident #2 was being transported out the shower stall using the shower chair. As the wheels of the chair approached the uneven surface between the shower to the floor, the chair tipped over. The resident fell to the floor landing onto his/her right side. The resident hit the left side of the head and knee that resulted in abrasions. The incident report evidences that the manager notified his/her supervisor who would inquire whether the bump in the floor can be repaired, as that is a contributing factor.

Per review of electronic mail (e-mail) from the manager to the guardian dated 10/23/18, identifies an ongoing issue with the bump on the bathroom floor where the floor transitions into the shower, causing somewhat of a trip hazard. Also, the facility acknowledges a new shower chair, that is much lighter than the old, heavier shower chair being another contributing factor. The guardian responded on 10/23/18 suggesting that a person who does flooring evaluate. The manager's response dated 10/24/18 via e-mail documents, that unfortunately the floor is an expensive repair, we have talked about it and my understanding is nothing can be done at this time, it is on the list for longer term house repairs/upgrades. Further response from the guardian identified that this is a health and safety issue.

Per review of the work order, approval was

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received on 11/9/18.
On 11/14/18 the maintenance work identified that a steep short incline into the shower would fix the problem.
On 11/19/18 the work order is complete.

There is further documentation from the supervisor, identifying the men's bathroom floor continues to be a problem getting clients in and out of the roll-in shower while in the shower chair. It has led to several falls/injuries and has become a safety issue. The issue is surrounding the ongoing struggle with the steep/short incline into the shower.

E-mail dated 12/21/18 to the maintenance worker from the senior supervisor identifies that the ramp that has been installed has only created a more treacherous/dangerous situation for clients and staff.

Per observation on 1/7/19 at approximately 11:30 AM the maintenance worker removed the metal ramp. Since the ramp is no longer present, there continues to be an uneven surface between the floor and the edging of the shower that creates an ongoing hazard for transporting residents in and out of the shower stall via the shower chair.

4. Per observation on 1/7/19 of the shower room on the male side of the building, evidences an exhaust fan heavily accumulated with dust and grime. The ramp leading into the shower stall is dirty with brown stains, the flooring on both sides of the ramp have visible dried yellow substance and the room itself is foul smelling. Once the ramp was removed (1/7/19), standing water was exposed on the floor.

The transition continues to be a problem. While

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R266	Continued From page 5 on site the maintenance worker removed the ramp, exposing standing water on the floor, foul odor and dirty/grimy residue on the floor. The Manager confirms during the day long investigation that all of this evidence identified is present and adds that the trash needs emptying. 5. Per observation of Resident#2's bureau, the drawers are missing two knobs. Visible screws are present with the sharp points exposed.	R266		

JAN 23 2019

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

HOWARD CENTER
Help is here.

January 16, 2019

Dear Ms. Cota:

Listed below are the plans of correction for each deficiency cited in the unannounced on site anonymous complaint investigation at Pennington Group Home, 1822 North Avenue RCH of Howard Center Developmental Services that took place on January 7, 2019.

R145 V. Resident Care and Home Services

5.9.c. Plan of Care

1. The Residential Manager, Erin Daigle, updated the Residential Plan of Care for Resident #1 on 1/7/2019. The update addressed the fall that Resident #1 had in the shower on 8/4/18; providing the guidelines for supporting the resident while in the shower and with all transfers. The updated Residential Plan of Care reflects the most recent care and services necessary to assist the resident to maintain their independence and well-being. The Plan of Care for Resident #1 was reviewed and signed off by the Team Lead, Senior Manager, the facility Nurse, and the Clinical Director. To ensure that deficient practices do not recur the Residential Manager will review the Residential Plan of Care's monthly to verify that all information is current, accurate, and up-to-date. Corrective action is complete.
2. The Residential Manager, Erin Daigle, updated the Residential Plan of Care for Resident #1 on 1/7/2019. The update addressed the fall that Resident #1 had in the shower on 10/23/18; providing the guidelines for supporting the resident while in the shower and with all transfers. The updated Residential Plan of Care reflects the most recent care and services necessary to assist the resident to maintain their independence and well-being. The Plan of Care for Resident #1 was reviewed and signed off by the Team Lead, Senior Manager, the facility Nurse, and the Clinical Director. To ensure that deficient practices do not recur the Residential Manager will review the Residential Plan of Care's monthly to verify that all information is current, accurate, and up-to-date. Corrective action is complete.
3. The Residential Manager, Erin Daigle, updated the Residential Plan of Care for Resident #2 on 1/7/2019. The update addressed the fall that Resident #2 had in the shower on 10/27/18; providing the guidelines for supporting the resident while in the shower and with all transfers. The updated Residential Plan of Care reflects the most recent care and services necessary to assist the resident to maintain their independence and well-being. The Plan of Care for Resident #2 was reviewed and signed off by the Team Lead, Senior Manager, the facility Nurse, and the Clinical Director. To ensure that deficient practices do not recur the Residential Manager will review the Residential Plan of Care's monthly to verify that all information is current, accurate, and up-to-date. Corrective action is complete.

R266 IX. Physical Plan

9.1. Environment

102 South Winooski Avenue, Burlington, VT 05401
T: 802.488.6500 | F: 802.488.6501
HowardCenter.org
Member Agency of United Way of Chittenden County

1. Due to the fall Resident #1 had on 8/4/18, the Team Lead, Amy Quaglietta, followed up with the Facilities Manager to schedule a flooring company to come and survey the uneven surface between the floor to the shower, and to schedule a time for the flooring company to correct the issue, in the immediate future. On 1/7/19 Able flooring came to Pennington and reviewed the uneven surface and ordered the supplies needed to complete the job. Able flooring came to Pennington on 1/16/2019 and evened out the flooring from the shower to the floor to make for an easier and safer transfer in and out of the shower stall. To ensure that deficient practices do not recur the Residential Manager will carefully review all incident reports related to falls and communicate with staff regularly to find out if there are any concerns or issues surrounding the floor and transferring clients in and out of the shower stall. Corrective action is complete.
2. Due to the fall Resident #1 had on 10/23/18, the Team Lead, Amy Quaglietta, followed up with the Facilities Manager to schedule a flooring company to come and survey the uneven surface between the floor to the shower, and to schedule a time for the flooring company to correct the issue, in the immediate future. On 1/7/19 Able flooring came to Pennington and reviewed the uneven surface and ordered the supplies needed to complete the job. Able flooring came to Pennington on 1/16/2019 and evened out the flooring from the shower to the floor to make for an easier and safer transfer in and out of the shower stall. To ensure that deficient practices do not recur the Residential Manager will carefully review all incident reports related to falls and communicate with staff regularly to find out if there are any concerns or issues surrounding the floor and transferring clients in and out of the shower stall. Corrective action is complete.
3. Due to the fall Resident #2 had on 10/27/2018, the Team Lead, Amy Quaglietta, followed up with the Facilities Manager to schedule a flooring company to come and survey the uneven surface between the floor to the shower, and to schedule a time for the flooring company to correct the issue, in the immediate future. On 1/7/19 Able flooring came to Pennington and reviewed the uneven surface and ordered the supplies needed to complete the job. Able flooring came to Pennington on 1/16/2019 and evened out the flooring from the shower ot the floor to make for an easier and safer transfer in and out of the shower stall. To ensure that deficient practices do not recur the Residential Manager will carefully review all incident reports related to falls and communicate with staff regularly to find out if there are any concerns or issues surrounding the floor and transferring clients in and out of the shower stall. Corrective action is complete.
4. The Residential Manager, Erin Daigle, cleaned the exhaust fan on 1/7/19 and followed up with staff during the next team meeting on 1/16/19 about the importance of maintaining a safe, functional, sanitary, homelike, and comfortable environment. The ramp leading into the shower stall was removed on 1/7/19 and the floor was cleaned to remove the visible stains and odor in the bathroom. New trash cans were ordered and arrived at Pennington on 1/14/2019 that have a secure lid and control the odor from soiled Depends. To ensure that deficient practices do not recur the Residential Manager has created a cleaning-task checklist that staff will use to remind them of all necessary cleaning that needs to be completed during each shift. The Residential Manager will complete daily walk-throughs of the house and will follow up with the staff as necessary to complete cleaning tasks. Corrective action is complete.
5. The Residential Manager, Erin Daigle, completed a job order to facilities requesting that Resident #2's bureau nobs be replaced. This was completed on 1/8/19. To ensure that deficient practices do not recur the Residential Manager will complete daily walk-throughs of the house to ensure that all furniture in the house is safe and will complete a job order as needed to fix or replace any furniture. Corrective action is complete.

Please feel free to contact me with any questions or comments.