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

August 14, 2018

Ms. Kim Russell-Peck, Manager
Kirby House, Inc.
64 South Main Street
Waterbury, VT 05676-1517

Dear Ms. Russell-Peck:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 17, 2018.** 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

PRINTED: 07/26/2018
FORM APPROVED

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
	0058	A. BUILDING: _____ B. WING _____	C 07/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIRBY HOUSE, INC.	64 SOUTH MAIN STREET WATERBURY, VT 05676

(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: The Division of Licensing and Protection conducted an unannounced on site investigation of a complaint and facility self-report on 7/16/2018-7/17/2018. The following regulatory violations were identified.	R100		
R145 SS=G	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 staff interview and record review, the residence failed to ensure that the Registered Nurse developed a plan of care based on identified resident needs and included the care and services necessary to assist with the maintenance of independence and well-being for one applicable resident (Resident #1). Findings include: Resident #1 was admitted to the residence in 1999 with a primary diagnosis of a psychiatric illness. Per record review, Resident #1 was 67 years old and prescribed medications included clozapine (antispychotic) 300 mg daily and risperidone (antipsychotic) 0.25 mg daily. Per review of legal paperwork present in the record, Resident #1 had impaired insight and judgement	R145	POC accepted R145/R266 RSmrbock, RN 8/8/18	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Russell-Bell 8/7/18	Manager	

Division of Licensing and Protection

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R145	Continued From page 1 about the necessity of treatment, and would not be able to recognize his/her "own decline and would not ask for additional treatment due to high intensity psychotic residual symptoms". Resident #1 exhibited behavior including wearing excessive layers of clothing. At approximately 12:35 AM on 7/3/2018, Resident #1 was found on the floor of his/her room at the residence by direct care staff conducting safety checks on residents during rounds of the facility. Per Progress Notes documentation, Resident #1 was "breathing steadily", unconscious and unable to be woken. Resident #1 stopped breathing just as Emergency Medical Technicians (EMTs) arrived at the residence. Emergency responders attempted cardiopulmonary resuscitation (CPR), but Resident #1 did not regain consciousness and died at the residence. Per review of January 2018 Nurse Progress notes, Resident #1 was, "reluctant to accept care" from the Registered Nurse, and an April 2018 Nurse Progress note states, "client refuses all other nursing care". Resident #1's Behavior Management Plan states that, "staff will refrain from touching...unless in an emergency" and the Plan of Care states Resident #1, "will only wear button up shirts, a blazer and jeans, as well as only wearing cowboy boots." Upon review, there was no evidence of Resident #1's vital signs having been obtained at the residence. During an interview on 7/16/2018, the Registered Nurse confirmed that Resident #1, "wouldn't let anybody touch" him/her and refused nursing care at the residence, including having vital signs taken. The Registered Nurse provided no additional information to direct care staff about Resident #1's specific risk factors of dehydration and heat stroke due to their prescribed antipsychotic medications and advancing age. Direct care staff	R145		

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R145	Continued From page 2 reportedly made ongoing attempts to encourage Resident #1 to remove excessive layers of clothing, however there were no specific interventions in the Care Plan to consistently guide staff in their interactions with Resident #1. The Registered Nurse confirmed there were no interventions included in the Care Plan to address these areas of concern. Resident #1's Plan of Care failed to include interventions to address their refusal of vital signs and nursing care, pattern of wearing excessive clothing, and medication side effect risk factors. The findings were reviewed with the Registered Nurse and Residence Manager on 7/16/2018.	R145		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 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 observations and interviews, the residence failed to ensure that all areas of the home were maintained in a safe, comfortable and homelike environment. This has the potential to effect all residents. Findings include: During an environmental tour at 1:30 PM on 7/16/2018, the ambient air temperature on the third floor of the residence were measured to be 80 degrees. While one portable air conditioning unit was present and running at the end of the	R266		

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R266	Continued From page 3 hallway, a resident whose room was on the third floor told the Nurse Surveyor that it, "felt warm" and they "felt kind of stressed" about the temperature in the residence. At 1:40 PM on 7/16/2018 the ambient air temperature on the fourth floor of the residence was measured to be 78 degrees in the area of the portable air conditioning unit. A resident whose room was near the air conditioner confirmed s/he did feel warm and utilized fans in their room to help with the heat. The ambient air temperature at the end of the fourth floor farthest from the air conditioner unit was measured to be 82 degrees at 1:45 PM. A resident whose room was at this end of the hall told the Nurse Surveyor that the heat was uncomfortable and that, "a breaker keeps going off" and there are periods of time when the air conditioner is not running. Per interview, the resident stated, "staff have to come up here to fix the breaker...and the air conditioner is shut off" until staff arrive. The Residence Manager confirmed during an interview on 7/16/2018 that two new portable air conditioning units had been purchased and installed during the recent period of extreme heat. Per interview, the Residence Manager confirmed that the electrical system of the building "gets overwhelmed", and the electrical circuit gets overloaded while the air conditioners are running, requiring the breaker boxes needing to be reset.	R266		

POC –R145

RN will review and update care plans to address specific needs of client. When clients consistently refuse medical care this RN will document refusals and make report to psychiatric provider and case management if applicable. RN will work together with psychiatric provider and case management to assess what steps should be taken to assure the clients health and safety. If RN is concerned that client is not capable of maintaining their own health and making informed decisions that display insight into their own condition and the ability to make rational decisions this will be reported to psychiatric provider and case management. If client does not have a psychiatric provider this RN will speak with Primary care for assessment.

Staff training will be provided on common side effects and adverse reactions to commonly used psychiatric medications. Staff will continue to push fluids when appropriate in hot weather. Any clients who are dressing overly warm on very hot days will be encouraged to dress more appropriately and be reminded to drink more fluids. If clients refuse to adhere to dressing appropriate for weather and consuming more fluids WCMHS screeners will be notified to come and evaluate client's ability to make their own decisions and decide if inpatient hospitalization is required.

All refusals of care will be documented and reported to primary care and/or psychiatric providers. Annual care plan updates will be evaluated by interdisciplinary team once a year +PRN to address any concerns any staff member may report about an individual client.

Weekly management meetings will be held to discuss any clients who may be at a higher risk and need closer monitoring long or short term.

These corrective actions will be put into place immediately and all care plans will be updated with this information as each need arises. Staff training on antipsychotic side effects will be completed no later than 8/30/18. Written documentation of this training will be obtained. Any staff unable to demonstrate working knowledge of common side effects/risk factors or the inability to use the provided drug guide effectively will no longer be delegated to provide care under this RNs license.

POC-R266

Although our electrical system will not support individual air conditioners in bedrooms we have at least one fan on each bedroom and staff check each several times on all three shifts during high temperatures. We have air conditioning in some common areas of the house and residents are encouraged to utilize these areas anytime day or night.

To clarify the resident comment about "staff have to come up here to fix the breaker...and the air conditioner is off". When the breaker is tripped the power for all the bedrooms on two floors is out. Staff responds to this immediately by restarting the breaker and looking for the cause. This is usually a coffee pot or hair dryer.

On 7/25/2018 Wayne Moore from the Fire Marshalls office and Wayne Dunlap, Electrical Inspector were here to investigate. Also Benoit Electric conducted a safety check and measured the load on each breaker and concluded that none were overloaded.

We have asked residents to avoid using coffee pots and hair dryers while hallway air conditioners are in use. We have added checking on these items to housekeeping and shift duties to avoid any interruption in power.

Management will review with all staff, protocol for electrical disruption during RN in-service no later than 8/30/2018.

Kim Russell-Peck

Manager, Kirby House

8/06/2018