

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 12, 2012

Ms. Kim Russell-Peck, Administrator
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 **September 11, 2012**. 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

PC:jl



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KIRBY HOUSE, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 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: An unannounced on-site complaint investigation survey of multiple complaints was conducted on 9/10/12 & 9/11/12 by the Division of Licensing and Protection. There were regulatory deficiencies identified during the survey as follows:	R100		
R145 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (2)</p> <p>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;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assure the development of a care plan which describes the care and services needed to assist the resident to maintain independence and well-being for three (3) residents in a sample of four (4). Findings include:</p> <p>1). For Resident #2 the Care Plan lists his/her behaviors as: Assaultive, Agitated, Self-Harm, Withdrawn, Elopement, and Anxiety. Although these behaviors are listed there are no interventions provided in the Care Plan to be employed by staff to prevent, avoid, or de-escalate the identified behaviors.</p> <p>2). For Resident #3 the Care Plan lists his/her behaviors as Assaultive, Agitated, and Suicidal.</p>	R145	<p>For the care plans reviewed upon survey interventions have been identified and added to their plan of care. These interventions would be used by staff to prevent, avoid or de-escalate the behaviors identified in plans.</p> <p>We are currently reviewing all care plans and adding interventions that may be appropriate for already identified behaviors and from this point forward any new care planning will include this step.</p>	<p>10/11 ROC ACCEPTED m.hugerson 10/31/12</p>

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kim Russell

TITLE

manager

(X6) DATE

pm

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2012	
NAME OF PROVIDER OR SUPPLIER KIRBY HOUSE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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
R145	Continued From page 1 Although these behaviors are listed there or no interventions provided in the Care Plan to be employed by staff to prevent, avoid, or de-escalate the identified behaviors. 3). For Resident #4 the Care Plan lists his/her behaviors as Anxiety, Assaultive, Withdrawn, and Agitated. Although these behaviors are listed there are no interventions provided in the Care Plan to be employed by staff to prevent, avoid, or de-escalate the identified behaviors. The above was confirmed with the facility Manager on 9/10/12 at 4 PM.	R145		
R181 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions.	R181	We have requested and received any and all missing records checks for the employees identified with incomplete files. Currently, prior to hire, these records checks are performed on all prospective employees. All employee files will be monitored on an annual basis to check for completeness.	40/11 POC ACCEPTED 10/31/12

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2012	
NAME OF PROVIDER OR SUPPLIER KIRBY HOUSE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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
R181	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that there was no person on staff who had a charge of abuse, neglect, or exploitation substantiated against him or her. Findings include: In a records review for five (5) randomly chosen staff members the file showed no evidence of adult and child abuse registry checks for one (1) staff member and no evidence of adult abuse registry checks for an additional three (3) staff members. The finding was confirmed by the facility Manager and facility Owner on 9/12/12 at 3 PM.	R181		
R200 SS=D	<p><i>*Although we agree with the findings</i></p> <p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.15 Policies and Procedures</p> <p>Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews the facility failed to assure that written procedures for all services provided were available for review. Findings include:</p> <p>Per record review Resident #1 had expressed suicidal ideation on 6/12/12 and Resident #3 is identified as having Suicidal behaviors at times. In an interview at 3:30 PM on 9/10/12 the facility Manager stated that the facility practice is to call the Mental Health screeners anytime a resident</p>	R200	<p><i>we believe that this statement is inaccurate in the fact that the survey included a review of all 17 employee records not just 5.</i></p> <p><i>R200 A suicide/self harm policy and protocol has been developed and reviewed by administration, our Registered Nurse and the Washington County Mental Health Crisis team. An educational</i></p>	<p><i>10/11</i> <i>POC ACCEPTED</i> <i>mlygms</i></p> <p><i>10/11</i> <i>POC ACCEPTED</i> <i>mlygms</i></p>

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2012
NAME OF PROVIDER OR SUPPLIER KIRBY HOUSE, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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
R200	Continued From page 3 expresses suicidal ideation to receive guidance. S/he stated that there is no written policy to address or reflect this and no written procedures for staff to follow to assure resident safety when they have expressed such ideation.	R200	training will take place on 10/29/12 for all employees to go over our current protocol and practice using the resources available. Additional material will be presented by a outside educator in regards to suicide and the prevention of.	10/11 POC ACCEPTED m/8/11/12 RN 10/13/12