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

February 18, 2025

Dexter Agasi, Manager
Our House Too Residential Care Home
196 Mussey Street
Rutland, VT 05701

Dear Mr. Agasi:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 17, 2024**. 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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
	0377	A. BUILDING: _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE TOO RESIDENTIAL CARE HOME	196 MUSSEY STREET RUTLAND, VT 05701

(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 onsite relicensure survey was conducted by the Division of Licensing and Protection on 12/16/14 and completed on 12/17/24. The following regulatory violations were identified.	R100		
R104 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy. (1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the	R104	Admission agreements have been edited to include the location. All resident charts are being updated. Owner will monitor for compliance as the the owner is the only person who presents pre-admission and admission packets. R104 Accepted Jenielle Shea, RN 2/18/25	1/24/25

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R104	Continued From page 1 ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Residential Care Home (RCH) failed to ensure the admission agreement for 5 out of 5 residents utilized included the necessary information within the admission agreement. Upon review of the facility admission agreements, the agreement's produced language in which residents' sign upon admission is not specific to the home in which the resident is admitted. The governing body owns and operates 3 individually licensed homes including "Our House Too". Within the admissions agreement terms, the identifying home is named as "Our House Residential Care Homes", not the individually licensed home's operating name. The RCH license to operate named "Our House Too" has a licensed special care unit. The agreement does not include the description of services rendered by the special care unit. Per interview on 12/16/24 at 3:00 PM, the Owner confirmed all the owned and operating licensed homes, including "Our House Too", utilize the same admission agreements and are listed with "Our House Inc" which is the businesses name. The Owner acknowledged "Our House Too" is the facility name listed on the license to operate and does not appear on the admissions agreement for the home as the rendering provider of services. The Owner acknowledged the current admissions agreement language is not	R104		

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R104	Continued From page 2 constructed to be specific to identify the licensed home and does not include the operation of an approved special care unit. The Owner did note, residents who received funding sources from ACCS and ERC have an alternative format of an agreement to identify financial agreements and terms. Per record review, 1 out of 3 resident's agreements failed to include services provided under the ACCS program. Resident # 1's agreement failed to include the ACCS services, to include the specific room, board rate and the amount of personal needs allowance. Additionally, the agreement was signed on 2/8/16. On 12/16/24 Resident #1 was approved for Assistive Community Care with Enhanced Residential Care (ERC) services. At the time of review the Manager confirmed to not have updated the agreement with changes in financial status with SSI/ACCS/ Medicaid funding. See tag 107.	R104		
R107 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.2 Admission 5.2.a (4) If the home agrees to accept SSI or ACCS payments and allows the resident to remain in the home when the resident's financial status changes, the home must provide the resident with a new admission agreement as provided to all ACCS participants. This REQUIREMENT is not met as evidenced	R107	Resident admission agreement has been updated to the ACCS admission agreement and ERC addendum. Agreement has also been updated to the specific location. The owner will monitor for compliance as the owner is the only person who presents admission documents for private pay and LTC medicaid residents. R107 Accepted Jenielle Shea, RN 2/18/25	1/20/25

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R107	Continued From page 3 by: Based on staff interview and record review the RCH failed to complete an updated admission agreement for 1 resident of the sample, that was receiving Assistive Community Care Services (ACCS). Findings include: Per record review on 12/16/24 Resident #1 was approved for Assistive Community Care with Enhanced Residential Care (ERC) services. The last signed agreement in the record was completed 2/8/16. Per interview on 12/16/24 at 3:25 PM the Owner confirmed Resident #1's admissions agreement had not been updated since being approved for ACCS. The Owner acknowledged the requirement to update admission agreements when financial status changes occur, with acceptance to ACCS and ERC programs and when changes to fundings occurs with identified programs.	R107		
R112 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.2 Admission 5.2.d On admission each resident shall be accompanied by a physician's statement, which shall include: medical diagnosis, including psychiatric diagnosis if applicable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the RCH failed to esnure the admission of 1 out 5 residents included a physician statement.	R112	Physicians statements have been requested and will be filed in the resident chart once received completed. This was an isolated incident and will not repeat- Owner, Manager and RN monitor PCP's admission documents for compliance and audit for accuracy. R112 Accepted Jenielle Shea, RN 2/18/25	1/27/25

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R112	Continued From page 4 Per interivew on 12/16/24 at 3:30 PM, the Owner acknowledged to have admitted Resident #4 on 11/22/24 from another licensed and operated home by the Owner. The Owner confirmed updated physician statements were not completed upon the admission to Our House Too Residential Care Home.	R112		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to ensure that medications were administered per physician's orders for one out of five residents in the applicable sample (Resident #1). Findings include: Per record review, Resident # 1's Medication Administration Record (MAR) for 12/1/24 - 12/31/2024 reflects a physician's order for Fluphenazine 2.5mg/ml intramuscularly injection to be administered every 2 weeks which is due December 12th and December 26th. The MAR was not documented on 12/12/24 to indicate the Fluphenzine injections was administered. The resident record did not include documentation in form of a progress note to account for the missed dose.	R128	RN's have been reminded of the importance of accurate documentation and that documentation must be made at the time of occurrence. Manager will document delayed orders in the MAR and in the residents ADL's on a care service note with dates and details - a facility to Nurse note will also be completed and left for the RN to follow through until the medication is received and administered. Manager will monitor for compliance/ R128 Accepted Jenielle Shea, RN 2/18/25	12/30/24

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R128	Continued From page 5 Per interview, on 12/16/24 at 2:30 PM the Manager confirmed the medication was not available for the RN to administer. Within the resident record an electronic prescription of the medication was on file dated 12/13/24. The Manager confirmed a new prescription was required to refill the medication. At the time of finding, on 12/16/24, the medication had not been delivered by the pharmacy and was unavailable to be administered. Per interview on 12/16/24 at 3:00 PM, the Owner confirmed the RN is aware and indicated documentation of the missed dose is recorded with a medication error report, however the documentation was in the office, and not within the facility for review by staff or manager. In a follow up interview on 12/17/24 the Owner was unable to provide the documentation for review as the RN was unavailable to provide it them. The facility policy and procedure titled "Documentation of Medications", indicates "If medication were refused or withheld, the staff person circles his/her initials on the medication administration record and writes a progress note explaining the reason why and the action taken by the facility."	R128		
R135 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission	R135	Assessments have been updated with the new admission dates and locations have been edited. RN's have been reminded that the assessments must be accurately completed, dated, signed and reviewed by the Manager prior to being filed in the resident charts. Manager and owner will monitor for accuracy, completion and compliance.	12/30/24

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R135	Continued From page 6 to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to complete an initial assessment within 14 days of admission for two applicable residents (Resident #3 and #4). Findings include: Per record review on the morning of 12/16/24 Resident # 3 and Resident # 4 was admitted to the Residential Care Home (RCH) on 11/22/24. A Vermont Resident Assessment was not completed by the admitting RCH with the admission to the RCH. Both Resident #3 and #4 previously resided within another owned and operated care home by the owner. The Vermont Resident Assessment completed for Resident #3 indicated "reassessment" dated 11/16/24, with an admission date of 11/21/2018, with the facility indicated as only "Our House". The Vermont Resident Assessment completed for Resident #4 indicated, "reassessment" dated 11/26/24, with an admission date of 3/29/23, with the facility indicated as only "Our House". Per interview on 12/17/24 at 2:00 PM the Owner explained both Resident # 3 and # 4 were admitted from another community S/he owned and operated. Through the interview the Owner confirmed the records did not contain completed Resident Assessments within 14 days of admission to the current RCH in which Resident's #3 and #4 reside.	R135	R135 Accepted Jenielle Shea, RN 2/18/25	

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R135	Continued From page 7 The facility policy titled Assessment and Care plans indicates "Care plans must meet resident's needs, physically and emotionally. Assessments (using the State Resident Assessment form) must be created as soon as possible and not later than 14 days after admission".	R135		
R145 SS=F	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 RCH failed to establish a written care plan that reflected all the care needs and problems impacting 4 out 5 applicable resident. (Resident #1, # 2, #3, #4) Findings include: 1. Per record review Resident #1 received coumadin which is classified as an anti-coagulant. Resident #1's care plan does not identify care and services with receiving coumadin. His/her plan of care does not identify the risk for bleeding associated with administration of anticoagulant medication; and interventions related to this risk such as precautions to minimize the risk of bleeding, signs and symptoms of internal bleeding, and	R145	Care plans are being rewritten by RN's . Manager and RN will create the care plans together for accuracy- RN and Manager will review periodically or when a change in status occurs warranting a new or edited care plan, or at minimum annually when the assessment is updated. RN and Manager will monitor for compliance. R145 Accepted Jenielle Shea, RN 2/18/25	1/30/25

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R145	Continued From page 8	R145		

when to seek medical help for uncontrolled bleeding.
Per interview on 12/17/24 at 2:15 PM the Owner confirmed the care plan for Resident #1 does not include care services related to receiving anticoagulation medications.

2. Per observation during the lunch meal on 12/16/24, staff supported Resident #2, with positioning of utensils within hand, verbal prompts with eating and visual monitoring providing assistance as needed.

Resident #2's resident care plan identifies diet to be "Regular" with no other intervention indicated. Within the resident record, a hospice case conference summary conducted in 8/21/24 noted, "started nectar thicket for choking concerns".

Per interview on 12/17/24 at 2:30 PM the Owner confirmed, Resident #2 may receive nectar thicken liquids as needed, the Owner additionally confirmed the plan of care does not indicate the dietary changes initiated by hospice on 8/21/24.

3. Per record review, Resident #3's care plan was last updated on 11/30/2019. The resident resided in another licensed and operated home by the owner, the Resident moved to the current facility in November 2024, a care plan had not been developed in their current facility to indicate necessary care and services required to support well-being and independence.

4. Per record review, Resident #4's care plan was last updated on 3/20/22. The resident resided in another licensed and operated home by the owner, the Resident moved to the current facility in November 2024. A care plan had not been developed in their current facility to indicate the

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R145	Continued From page 9 necessary care and services required to support well-being and independence. Per interview, The Owner confirmed the records and care plans for Residents #3 and #4 are a continuation from the Resident's previous facility which is separately licensed and operated by the owner. The Owner confirmed the care plans have not been updated since the noted dates, nor have care plans been established with admission to the currently admitted home. The facility policy titled Assessment and Care plans indicates that Care plans must meet resident's needs, physically and emotionally. Assessments (using the State Resident Assessment form) must be created as soon as possible and not later than 14 days after admission.	R145		
R150 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview progress notes for 2 out 5 Residents (Residents #1, and #2) did not include documentation of occurrences and follow up care to meet resident care needs. Per record review, Resident #1's record included a facility nurse note on 12/14/24 indicating	R150	Care service notes are being used routinely by RN and Manager to capture and communicate a chronological narrative of symptoms or signs of illness, accidents and incidents from the onset to resolve. RN and Manager will monitor for accuracy and compliance. R150 Accepted Jenielle Shea, RN 2/18/25	12/30/24

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R150	Continued From page 10 Resident #1 to have experienced what appeared to be bleeding at time of a bowel movement. The nurse stated, " bowel protocol should be reviewed to confirm that stools are not too hard if it continues." Resident #1 receives anti-coagulation medications, in which increases risks of bruising and bleeding. The record did not include nurse assessment, provider communication with follow up care and monitoring, or nursing action to demonstrate monitoring of symptoms. Per record review, Resident #2 was seen at the hospital 2/29/24, 4/2/24, 5/2/24, 5/10/24. Resident #2's record did not include notations at the time of occurrence to account for the occurrences requiring hospital visits and necessary care to provide to Resident #2 monitoring. A Hospice nurse note documented on 11/26/24, Resident #2 had experienced a fall prior to their visit, during the night, at 0100 hours, noting the resident to have a laceration above left eyebrow. The resident record did not include facility initiated documentation of the occurrence, assessment, or care intervention implemented. Per interview on 12/17/24 at 1:10 PM the Manager confirmed the record does not include progress notes of the occurrences experienced by Resident #1, and #2.	R150		
R160 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The	R160		

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R160	Continued From page 11 policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on staff interview, the home failed to ensure medication policies were established and updated to current practices. The facility manager was requested to provide medication management policy and procedures the RCH utilizes for the administration, documentation and procurement of medications. Upon receipt of the policies, a procurement policy	R160	*Provider does not agree with surveyor findings.* Medication Policies and Procurement are in a separate tab within the policies and procedures binder. The Manager has been reminded to show the surveyor where the medication policies and procurement documents are located within the p&p binder, a new larger tab has been added for easily identifying the sections within the binder. Manager will monitor for compliance; owner will update as needed for compliance. R160 Accepted Jenielle Shea, RN 2/18/25	*2/14/25*

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R160	Continued From page 12 was not identified. Per interview on 12/17/24 at approximately 2:00 PM, the Owner confirmed a policy is not established for the procurement of medications.	R160		
R167 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home 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 staff interview and record review, the Registered Nurse failed to develop written plans for the administration of psychoactive PRN (administered as needed) medications by staff other than a nurse for three out five applicable resident's (Resident #1, #3, #4). Findings include: The home's PRN Psychoactive Medications policy states, "Staff who meet the criteria to	R167	Written behavior plans are being rewritten on an improved form by the RN. Written behavior plans will be filed with the MAR with the medication list and will be reviewed periodically or when necessitated by a change in medications or dose or frequency. A copy of the plan will also be kept in the residents ADL's. RN and Manager will monitor for accuracy and compliance. R167 Accepted Jenielle Shea, RN 2/18/25	1/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0377	A. BUILDING: _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE TOO RESIDENTIAL CARE HOME	196 MUSSEY STREET RUTLAND, VT 05701

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R167	Continued From page 13 administer PRN medications may administer PRN psychoactive medication ONLY WHEN A WRITTEN PLAN FOR THE USE OF THE MEDICATION HAS BEEN DEVELOPED ...[sic]" Per record review of the Medication Administration Records, the following as needed (PRN) psychoactive medications are ordered for Resident #1, #3 and #4: a.) Resident #1- December 2024 Medication Administration Record (MAR) includes orders for Haloperidol tablet 0.5 mg take 1/2 tablet (0.25 mg) by mouth twice daily ad needed or agitation/psychosis and Lorazepam 0.5 mg tablet, take 1 tablet by mouth at bedtime as needed for anxiety. b.) Resident #3- December 2024 MAR includes an order for Risperidone 0.25 mg, take 1 tablet by mouth daily as needed for anxiety/agitation. c.) Resident #4- December 2024 MAR includes an order for Risperidone 0.5 mg, take 1 tablet by mouth daily as needed for anxiety. Per interview on 12/16/24 at 1:30 PM, the Manager indicated written Behavior Plans are developed for each resident. The Manager explained the plans to identify dementia related behaviors each client may experience and interventions to support the resident when/if exhibiting the behaviors. Upon review of the Behavior plans, Resident #3 plan is developed by an RN, however, the plan is dated 4/4/22. Resident #4's plan is also developed by a RN, however, the plan was created on 9/22/22. Both Resident #3 and #4 were admitted to RCH on 11/22/24. Resident #3 and #4's referred behavioral plans were not updated by the current overseeing nurse for unlicensed staff to reference and be utilized with the administration of as need psychoactive medications. Per interview, the manager confirmed Resident	R167		

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R167	Continued From page 14 #1's behavior plan was developed by the Manager who is confirmed to be an unlicensed professional. In addition, the plans do not include the specific information required to describe the specific behaviors each medication(s) are intended to correct or address; specify the circumstances that indicate the use of the medication; and desired effects or undesired side effects the staff must monitor for, with administration of each individual psychoactive PRN medication. On the afternoon of 12/17/24 the Manager confirmed the Behavior plans are filed within the resident record, and not within the Medication Administration Record binder. The Owner referenced the Behavior Flow Sheets filed within the Medication Administration Record Binder. Upon review, the flow sheets do not include all information required in a written plan for the administration of PRN psychoactive medications by staff other than a nurse.	R167		
R188 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance	R188	Care service notes are being used routinely by RN and Manager to capture and communicate a chronological narrative of symptoms or signs of illness, accidents or incidents from onset to resolve. RN and Manager will monitor for accuracy and compliance. R188 Accepted Jenielle Shea, RN 2/18/25	12/30/24

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R188	Continued From page 15 directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to maintain and keep on file progress notes for all residents of the home. Findings include: Per record review 5 out of 5 sampled resident's charts did not contain Progress Notes. Progress Notes, defined by Taber's Medical Dictionary as "An ongoing record of a patient's [resident's] treatment...concerning the progress or lack of progress made by the patient [resident] between the time of the previous note and the most recent note", were not maintained in the resident's charts. In the morning of 12/17/24, the Manager noted the records to have staff to nurse communication records, in which the nurse provides follow direction in care and communication with staff with an identified concern. Per review Resident #2 record revealed through hospital discharge documentation to have experienced falls and medical evaluation on 2/29/24, 4/2/24, 5/2/24, 5/9/24, 5/22/24. A a visit summary completed by the hospice provider on 11/26/24, noted the resident to have experienced a fall during hours of sleep, 1:00 AM, prior to their arrival, Resident #2 sustained a head laceration as a result of the fall, with staff reporting bilteral lower extremity pain. Additionally, Resident #2 record included hospice documentation indicating Resident #2 was	R188		

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R188	Continued From page 16 admitted to hopsice in May 2024, the record did not contain progress to account for the resident's decline, transition to a hospice plan of care, and continued monitoring in necessary care needs or concerns. In full review of the resident record, progress notes were note completed to account for any accident or incident and subsequent follow-up, and/or changes in condition. Per interview on 12/17/24 at approximately 2:00 PM the Owner confirmed the facility did not have written policies and procedures related to staff maintain progress notes. Through the interview, the Manager and Owner confirmed the records to not include ongoing progress notes to account for resident concerns, events, incidents, and/or changes in condition or monitoring.	R188		