VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

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

July 7, 2025

Helen Bishop, Manager
Our House Too Residential Care Home
196 Mussey Street
Rutland, VT 05701

Dear Ms. Bishop:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 7, 2025**. 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 _____	C 05/07/2025

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 On 5/7/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of one complaint. The home was found to have a violation at the Immediate Jeopardy level related to the abuse of a resident by staff. The home was notified of the Immediate Jeopardy on 5/7/25, and submitted an acceptable immediate corrective action plan prior to the survey conclusion; however, deficient practice remains. The following deficiencies were identified:	R100	This Plan of Correction should be construed neither as an admission nor a denial of any wrongdoing by the licensee. This Plan of Correction is offered strictly to comply with the Residential Care Home Licensing Regulations and is subject to the licensee's right to appeal. Nothing in this Plan of Correction shall be deemed an admission, waiver or other representation impacting the licensee's right to appeal the deficiencies cited herein.	
R209 SS=F	5.11.b Staff Services The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the Residential Care Home (RCH) failed to ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents for 4 out of 5 Staff. Findings include: Per record review and interview on 5/7/25, the facility did not have a policy to ensure they maintained evidence of staff competencies on file. This was confirmed by the Owner on 5/7/25. Per record review on 5/7/25, the facility documented 4 out of 5 staff members sampled as having completed all 12 hours of training and all required competencies. Per interview, the Owner confirmed s/he himself/herself does not complete	R209	1. Policy Implementation: A formal policy will be adopted requiring verification of all required training and competencies before a new hire is permitted to begin work. This includes but is not limited to the already in place extensive orientation including video certification of Alzheimer's training from the Alzheimer's website. 2. Pre-Employment Audit Checklist: A standardized audit checklist will be completed by the administrator or designee for each new hire to ensure all required training documentation is received and reviewed prior to their start date. 3. Training Compliance Review: The designee will review training documentation for completeness during the hiring process. Staff will not be allowed to provide care until all required competencies and trainings are documented. 4. Ongoing Monitoring: Monthly audits of staff files will be conducted to ensure continued compliance. Any deficiencies will be corrected immediately and retraining provided if necessary. 5. Effective Date: This plan will go into effect immediately and all new hires forward will be subject to this policy. Responsible Party: Administrator/Designee Tag 209 is accepted on 5-23-25 by LTCM	5/30/25

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R209	Continued From page 1 or receive the required 12 hours of annual training or competency training, yet s/he provides direct care for Residents of the facility regularly. The Owner confirmed this finding on 5/7/25. Per interview and observation, staff of the facility did not demonstrate the adequate competencies required to provide direct care for the Residents of the facility. Per review of an interview conducted by the Attorney General's Office (AGO) with Staff #1 and #2 on 5/6/25, both Staff reported their position as direct care providers at the facility was their first in health care or residential care. Both staff reported they acknowledged 12 hours of training are required to provide care but stated they only received 4 hours of online training, and 4 hours of orientation. The orientation was reported to be provided to them in the form of a packet and was reviewed with both staff members by the Manager. Staff #1 and #2 reported being allowed by the Manager and Owner to provide direct care to Residents such as toileting, bathing, and lifting Residents without oversight, adequate training, or being assessed for competency. Per observation, interview, and record review, Resident #1 has a diagnosis of dementia and is totally dependent on staff for their Activities of Daily Living (ADL's). Resident #1 relies on a wheelchair pushed by staff for locomotion and requires full staff assistance for transfers in and out of the chair. Resident #1's diagnosis contributes to difficulty conversing and verbalizing needs to staff, and at times when agitated can become loud when anxious or excited. Resident #1's care plan identifies when they are escalated to use a "soft voice" and "give space" to address Resident #1's needs.	R209		

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R209	Continued From page 2 Per observation and interview on 5/7/25, the Manager demonstrated deficiencies in competency when providing direct care to Resident #1. On 4/24/25, the Manager was observed mistreating Resident #1 when Resident #1 was refusing care and escalated, by roughly grabbing the resident's body and their wheelchair. Per AGO interview conducted on 5/6/25, Staff #1 and #2 stated on 4/24/25 they heard and witnessed the Manager yelling at Resident #1 to "shut up" and attempting to force care to Resident #1. Per staff interview and observation of the facility video footage, the Manager was observed to grab Resident #1 by the back of the neck and yell in their face for them to stop being loud. The Manager was observed by video footage and staff to then wheel Resident #1 into the Resident's bedroom and close the door leaving both the Manager and Resident alone in the room. The footage also showed the Manager leaving Resident #1 alone in their room with the door closed, isolating the Resident from the rest of the home. During this time Resident #1 was yelling loudly for help. See Tag 360. Per interview with the Manager on 5/7/25, the Manager stated that Resident #1's escalated behavior is not unusual. The Manager and confirmed they were feeling anxious and stressed that day which was compounded by work stress on 4/24/25. The Manager confirmed their stress level caused their more direct quickened movements when working with Resident #1 on 4/24/25 and confirmed these behaviors should have been slower and calmer to help support and calm Resident #1. The Manager reported that when a staff member is stressed they are required to communicate with other staff and take a break from the facility to regulate. On 5/7/25, the Manager confirmed that on 4/24/25 they did	R209		

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R209	Continued From page 3 not feel they could take a break due to the two other staff on with the Manager, Staff #1 and #2, being new and inexperienced. Per interview on 5/7/25, the Manager confirmed they should not have closed the door while in the room with Resident #1 and should have involved Staff #1 and #2 for assistance when working with Resident #1. The Manager also confirmed that they did not follow the care plan indicating the need for a soft voice and to give the Resident space. The Manager also confirmed to obtaining video footage of Resident #1 on at least three separate occasssions on their peronal cell phone.	R209		
R213 SS=D	5.11.e (2) Staff Services The licensee must take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references, contacting the Division of Licensing and Protection, the Department for Children and Families and the Department of Public Safety's Vermont Criminal Information Center (VCIC) or another national background check vendor to see if prospective employees are on the Vermont abuse registries or have a record of convictions in any state or territory. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the Residential Care Home (RCH) failed to ensure to obtain annual criminal background checks for 1 out of 5 sampled staff. Findings include: Per per record review, the facility did not have all background checks for 1 staff member of the facility. The Owner of the facility is listed as a	R213	**Background check was updated with no findings.** **Annual rechecks follow hire dates for all.** **An electronic calendar reminder has been added to avoid overlooking any due dates.** **Further an electronic reminder is set one week after each due date to assure timely completion and compliance.** **Senior Manager will monitor for compliance.** Tag 213 is accepted on 5-23-25 by LTCM	**5/15/25**

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R213	Continued From page 4 employee of the facility on the facility employee roster. Per interview on 5/7/25, the Owner confirmed they have not and do not conduct annual criminal background checks on themselves yet does perform direct care to Residents of the facility regularly.	R213		
R232 SS=D	5.12.c (5) Records/Reports Any reports, allegations, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property must be reported to the licensing agency. i. The licensee and staff must report any case of suspected abuse, neglect or exploitation of a resident to Adult Protective Services (APS). A separate report must also be made to the licensing agency. APS may be contacted by calling toll-free 1-800-564-1612. The licensing agency may be contacted by calling toll-free 1-888-700-5330. The home must make the reports to APS and to the licensing agency immediately but not later than within 48 hours of learning of the suspected, reported or alleged incident. ii. In addition to filing the reports as described above, a home must conduct its own investigation and must take immediate steps to prevent further abuse, neglect or exploitation from occurring. The results of the home ' s investigation must be reported to the licensing agency within 5 business days from the date of the initial report of the allegation. The home's investigation and determination must not delay reporting of the alleged or suspected incident to	R232		

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R232	Continued From page 5 Adult Protective Services and to the licensing agency. iii. Incidents involving resident-to-resident abuse must be reported to the licensing agency any time a resident alleges, or the licensee or staff observe or suspect, verbal, physical or mental abuse; sexual abuse, if an injury has resulted; or if there is a pattern of abusive behavior. (A) All resident-to-resident incidents, even minor ones, must be recorded in the resident ' s record. (B) The home must notify legal representatives and families (if permitted) about the incident(s) and must document the report and the plan the home developed to address the behaviors. the following reports with the licensing agency: This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there is a failure to report an incident of reported or suspected resident abuse of Resident #1 by the home's Manager to the Licensing agency and the Adult Protective Services. Findings include: The home's "Reporting of abuse, neglect, and exploitation Policy [sic]" identifies the Licensee and Staff as mandated reporters who must report any case of suspected abuse, neglect, or exploitation to the Adult Protective Services. This policy is inconsistent with the licensing rules for Residential Care Homes, as the requirement to report to the Licensing Agency is not identified in the procedures. Per record review, Resident #1 is diagnosed with Alzheimer's Dementia and Generalized	R232	1. Immediate Reporting Policy: Staff have been trained from orientation and will have continued training that will be implemented and distributed to all staff stating that any suspicion, report, or observation of abuse, neglect, exploitation, or misappropriation must be reported immediately and directly to the licensing agency and APS, in accordance with state law. Staff are not required to use specific language (e.g., “allegation”) and may report any concern that may indicate potential harm. 2. Mandated Reporter Training: All staff, including the owner/manager, will complete mandated reporter training by covering: • Definitions and examples of abuse, neglect, exploitation, and misappropriation • Staff’s legal responsibility to report directly to the appropriate authorities • How and where to make a report • That reporting concerns to a supervisor does not fulfill their legal duty to report to APS and licensing 3. Resource Distribution: All staff availability to resources of a printed guide with contact information for APS and the licensing agency, along with a clear step-by-step guide on how to file a report. This guide will be reviewed in all new hire orientations moving forward. 4. Ongoing Education and Acknowledgment: Abuse reporting education has been and will continue to be reviewed annually with all staff. Staff will sign an acknowledgment form confirming they understand the reporting policy and their responsibilities as mandated reporters. 5. Responsible Party: The Administrator will ensure training completion, policy implementation, and compliance monitoring. Tag 232 is accepted on 5-23-25 by LTCM	5/30/25

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R232	Continued From page 6 Weakness; and is dependent on Staff for Activities of Daily Living . Resident #1 relies on a wheelchair pushed by staff for locomotion and requires full staff assistance for transfers in and out of the chair. Per observation of the home's video surveillance recordings, a recorded interview conducted by the Attorney General's Office (AGO) on 5/6/25 and record review, on the morning of 4/24/25 the home's Manager was observed by 2 Staff (Staff #1 and Staff #2) responding to Resident #1 repeatedly demonstrating refusal of nail care in a manner which was verbally and physically abusive. The Staff who witnessed the incident on the morning of 4/24/25 stated they observed the Manager yelling and cursing at Resident #1, shoving a chair at the dining room table, and grabbing Resident #1's neck as they were seated in a wheelchair at a dining room table. Per review of the home's video recording of this incident conducted on 5/7/25, during the incident in the dining room the Manager also aggressively turned and pulled Resident #1's wheelchair, grabbed the Resident's hands while performing nail care, and engaged in a physical struggle with the Resident. The Manager then wheeled Resident #1 into their assigned room, exited and closed the door. A few minutes later the Manager re-entered the Resident's room, closed the door, and remained in the room for over 5 minutes. Per review of an interview conducted with the Staff on 5/6/25 and a personal audio recording taken during the incident, Resident #1 could be heard loudly screaming "Help", "No", "Stop" and "Get out" while the Manager was in their room with the door closed. Staff #1 and #2 confirmed they reported this incident to the Owner of the home and met with the Owner on the afternoon of 4/24/25.	R232		

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R232	Continued From page 7 Per interview commencing at 12:15 PM on 5/7/25, the facility Owner confirmed they met with the Staff who witnessed the incident on the afternoon of 4/24/25 regarding actions taken by the Manager on the morning of 4/24/25. The Owner stated they saw the meeting with the Staff who witnessed the incident as an informative session and provided the Staff with information about Resident #1's personal history of traumatic experiences and abuse. The Owner confirmed they personally reviewed the home's video footage of the incident and met with the Manager after meeting with the Staff who witnessed the incident on 4/24/25. At approximately 12:30 PM on 5/7/25, the Owner stated they did not see the Manager's actions as abuse and they did not see a reason to file a report regarding the incident. On the afternoon of 5/7/25 the Owner confirmed they did not report the incident that occurred on the morning of 4/24/25 to the Licensing Agency. Per record review, this incident was also not reported to the Adult Protective Services.	R232		
R358 SS=E	6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced	R358	1. Policy Development and Implementation: A written policy will be developed and implemented to inform staff from prohibited using personal mobile devices to take or share any photos, videos, or audio recordings of residents, regardless of consent. This includes any content that could directly or indirectly reveal a resident's identity. 2. Staff Training: All staff have received training in orientation on the policy, emphasizing: • The importance of resident privacy and dignity • Prohibited use of personal devices in resident care areas • Legal and ethical implications of unauthorized sharing • Consequences of policy violations, including disciplinary action up to termination	

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R358	Continued From page 8 by: Based on observation, and staff interview the Residential Care Home (RCH) failed to ensure Residents (Resident #1) right to privacy was protected by staff. Findings include: Per record review, the facility did not have a policy regarding resident privacy that included the recording of Residents on Staff's personal devices. Per observation, interview, and record review, Resident #1 has a diagnosis of dementia and is totally dependent on staff for care for their Activities of Daily Living (ADL's). Resident #1 relies on a wheelchair pushed by staff for locomotion and requires full staff assistance for transfers in and out of the chair. Resident #1's diagnosis contributes to difficulty conversing and verbalizing needs to staff, and at times when agitated can become loud when anxious or excited. Per Interview and observation on 5/7/25, the Manager confirmed the symptoms and behaviors of Resident #1. The Manager then offered to show a video they had recorded of Resident #1 while in the facility as evidence to Resident #1's behaviors. Per observation, the videos contained short scenes on three different occasions of Resident #1 in their Wheelchair verbalizing toward the Manager while the Manager was recording with their phone in the Main dayroom and in their bedroom. The Manager confirmed the phone used to record Resident #1 was their personal phone. Per interview on 5/7/25, the Owner confirmed they were unaware the Manager had video recorded Resident #1 on their personal phone.	R358	3. Signs and Reminders: Clear signage will be posted in staff areas reminding personnel that personal device use for capturing or sharing resident information is strictly prohibited. 4. Ongoing Monitoring: The Administrator or designee will monitor compliance through regular walk-throughs and continued training during inservice trainings. Any violations will be addressed immediately. 5. Acknowledgment Form: All current and future staff will sign a policy acknowledgment form confirming their understanding and agreement to comply with privacy rules related to mobile device use. 6. Responsible Party: Administrator/Designee 7. Completion Date: Tag 358 is accepted on 5-23-25 by LTCM	**5/21/25** 5/30/25

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R360 SS=J	6.12 Resident's Rights Residents must be free from mental, verbal or physical abuse, neglect, and exploitation. Residents must also be free from restraints and seclusion as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the Residential Care Home (RCH) failed to ensure Resident #1 was free from abuse. Findings include: Per review of facility policy regarding abuse is not constant with the regulatory rules regarding abuse. Per observation, interview, and record review, Resident #1 has a diagnosis of "Alzheimer's Dementia" and "generalized weakness" and is totally dependent on staff for care for their Activities of Daily Living (ADL's). Resident #1 relies on a wheelchair pushed by staff for locomotion and requires full staff assistance for transfers in and out of the chair. Resident #1's diagnosis contributes to difficulty conversing and verbalizing needs to staff, and at times when agitated can become loud when anxious or excited. Resident #1's care plan identifies when they are escalated to use a "soft voice" and "give space" to address Resident #1's needs. Per review of Resident #1's Written Behavior Plan documented as prepared by the home's Manager on 4/1/24, "Care and toileting often cause anxiety. [Resident #1] may refuse ...Or yell loudly." This Written Behavior Plan instructs staff to, "Use a calm reassuring voice.", and reassure the resident they "are safe and no-one is going to	R360	1. Statement of Compliance: Effective immediately, the facility affirms that all residents have the right to live free from abuse, neglect, exploitation, and mistreatment. This includes physical, verbal, emotional, sexual, and financial abuse, as well as misappropriation of property. 2. Updated Reporting Policy: The policy has been revised to clearly state that staff are not required to use specific terminology such as “allegation” when reporting concerns. Any suspicion, observation, or disclosure of potential abuse must be reported directly to Adult Protective Services (APS) and the licensing agency, as required by law. Reporting to a supervisor does not fulfill this obligation. 3. Abuse Prevention Education: All staff and the facility owner/manager have completed abuse prevention and mandated reporter training in orientation. Owner will complete training. Training currently includes: • Definitions and examples of abuse, neglect, and exploitation • Recognizing signs and symptoms • Staff’s role and legal duty in reporting • Procedures for reporting directly to APS and the licensing agency • The importance of fostering a culture of safety and respect	5/9/25

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R360	Continued From page 10 hurt [them]." Per Interview with the facility Owner, it was confirmed that Resident #1 has a history of trauma and abuse and specifics domestic abuse in their past. Audio recorded Interviews with Staff #1 and Staff #2 were conducted by the Attorney General's Office (AGO) offsite on 5/6/25. On 5/7/25, footage from the facilities video surveillance recorded on 4/24/25 was provided by the facility and observed by surveyors. Per interview conducted on 5/6/25 by the AGO, Staff #1 and Staff #2 reported witnessing verbal and physical abuse by the facility's Manager toward Resident #1. On the morning of 4/24/25, both Staff #1 and #2 reported providing care together to Resident #1 in the facility's dining room with instructions from the Manager to remove the nail polish from Resident #1's fingernails. Both Staff reported Resident #1 resisted having their nails done, as evidenced by Resident #1 becoming louder vocally, and pulling their hands away when staff attempted to care for them. Staff felt the Resident was becoming escalated, so they decided to give the resident space and time as indicated as an intervention in Resident #1's care plan. During this time, the Resident continued to be escalated vocally and was hitting the table top with their hands. Both Staff reported this is usual behavior for this resident when anxious or excited. During this time, staff reported the Manager of the home came into the room on at least one occasion to try to calm the resident by calmly speaking to the Resident and putting their hand on the Resident's shoulder and back of the	R360	4. Preventive Measures: To prevent recurrence: • Abuse prevention policies and procedures will be reviewed with all staff yearly with an already scheduled inservice. Continued education happens with each inservice and on the job training. • Abuse reporting resource materials (contact numbers, guidance) is already posted in staff areas and included in orientation training. • A zero-tolerance policy for abuse will be enforced, including immediate investigation and disciplinary action for any violation. 5. Monitoring and Accountability: The Administrator/designee will follow up with any report of abuse and report to APS and licensing. 6. Responsible Party: Administrator/Designee 7. Completion Date: Tag 360 is accepted on 5-23-25 by LTCM	5/30/25

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	0377	A. BUILDING: _____ B. WING _____	C 05/07/2025

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R360	Continued From page 11	R360		

neck to try to de-escalate Resident #1. After a few minutes, the Manager was reported and observed in the homes video to exit the dining room so staff could continue to try to remove the nail polish. According to both Staff, Resident #1 remained escalated and continued with agitated behaviors of loud vocalizations and hitting the table with their hands, refusing care.

Staff reported hearing the Manager from another room yelling to Resident #1 to "shut up" several times. At 10:36 AM on 4/24/25 the Manager was observed re-entering the dining room and was observed to roughly shove a chair into the table where the Resident was sitting. The Manager positioned themselves on Resident #1's right side. Per observation and staff interview, the Manager grabbed Resident #1 by the back of their neck with their left hand and yelled into the Residents' face to "shut the f--k up". Per observation and staff interview it appeared the Resident's body stiffened in reaction to the Managers sudden and rough physical contact, and appeared their body slightly jolted as they were controlled by the Manager during this time. The Manager then exited the dining room 10:37 AM leaving the Resident alone.

Per observation of facility security cameras on 5/7/25, this action was verified, but the recording did not have audio. Staff #1 and #2 left the dining room at this time and reported feeling concern and fear due to the way the Manager interacted with Resident #1. Per staff interview on 5/6/25, and the facility's video surveillance footage on 5/7/25, at 10:39 AM the Manager re-entered the dining room and sat next to Resident #1 on their left side of their wheelchair and roughly positioned Resident #1's wheelchair toward them causing the Resident #1's body to jolt with the

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R360	Continued From page 12	R360		

movement. The Manager continued to try to provide care to the Resident by physically struggling with Resident #1 to have control of their hand. When Resident #1 pulled their hand back forcefully enough to break free from the Managers grasp, the Manager was witnessed to appear frustrated by suddenly standing up and quickly walking around the dining table, unlocked Resident #1's wheelchair and at 10:42 AM and quickly wheeled Resident #1 into their assigned bedroom, which was located off the living room area, and then exit the room shutting the door behind them leaving Resident #1 inside their room alone.

Per video observation on 5/7/25 and staff interview on 5/6/25, the Manager appeared agitated evidenced by their aggressive body movements and tense and forward body posture, moving quickly and roughly. The manager appeared to have an agitated facial expression as they worked with Resident #1 and moved around the facility. Staff #1 and #2 reported the Managers face as being "beet red" during this time. Staff stated they heard the Manager continuing to use profanity as they moved about the facility.

Per video observation, and staff interview, the Manager re-entered Resident #1's room at 10:46 AM and closed the door behind them so only the Manager and Resident #1 were alone in the room. Facility Video footage does not record inside residents' rooms, however, per observation of the video footage of the living room, the Manager was observed to be in the room alone with Resident #1 for over 5 minutes. Per interview with Staff #1 and #2 and through observation of personal audio recordings taken by both Staff during this time, Resident #1 can be heard to be

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R360	Continued From page 13	R360		

screaming loudly from within the room. Some of the Resident's words identified in the recording were identified as "Help", "No", "Stop" and "Get out".

Per observation of video footage and staff interview, Staff #1 and #2 entered Resident #1's room, at which point the Manager dismissed both staff from the room, and was again left alone with Resident #1. After a few minutes, the Manager exited the room and left Resident #1 in their room with the door open. Per interview with Staff #1 and #2 on 5/6/25, both staff members reported feeling uncomfortable with the incident and reported this incident to Staff #3 when they came on the afternoon shift at 2pm on 4/24/25, who instructed them to report to the Owner. Staff #1 and #2 contacted the owner via text together and requested them to report the incident discuss what happened with the owner after 2pm on 4/24/25.

Per interview with the Manager on 5/7/25, the Manager stated that Resident #1's escalated behavior is not unusual. The Manager confirmed they do get stressed while working at the facility at times, and on 5/7/25 reported they were feeling anxious and stressed on 4/25/25 when working with staff and residents. The Manager confirmed their stress level caused more direct quickened movements when working with Resident #1 on 4/24/25 and confirmed these behaviors should have been slower and calmer to help support and calm Resident #1. The Manager confirmed they frequently place their hands on Resident #1's back and neck as an action to calm Resident #1. Per interview with the Owner, they confirmed they have witnessed on occasions the Manager putting their hands on Resident#1's shoulders and neck and stated it was to calm them. It was

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R360	Continued From page 14 confirmed by both the Manager, Owner, and Staff #1 and #2 this technique of placing holds on Resident #1's is not on their care plan and no formal training has been identified for such therapeutic technique. Per interview with the facility Owner at 12:15 PM on 5/7/25, the owner confirmed that they had met with Staff #1 and Staff #2 per their request on 4/24/25 to discuss their concerns of what they witnessed. The Owner confirmed to viewing the facility video footage as to the incident reported to them by Staff #1 and #2 and confirmed they did not take any action on 4/24/25 or any time after. At approximately 12:30 PM on 5/7/25, the Owner stated they did not see the Manager's actions as abuse, and they did not see a reason to file a report regarding the incident. The Manager confirmed the meeting with both Staff #1 and Staff #2 around 2pm on 4/24/25 and de-briefed them on the trauma history of Resident #1 as a reason for their behaviors.	R360		
R363 SS=E	6.15 Resident's Rights Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge themself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these rules, the home may issue the resident a thirty (30) day notice of discharge in accordance with section 5.3.a of these rules.	R363		

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R363	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the Manager of the home failed to ensure Resident #1's right to refuse care. Findings include: During an interview commencing at 4:27 PM on 5/7/25 the Owner of the home confirmed policies and procedures governing the residents' right to refuse care have not been developed by the home. Per observation, interview, and record review, Resident #1 has diagnoses including Alzheimer's Dementia and Generalized Weakness; and is totally dependent on staff for Activities of Daily Living (ADL's). Resident #1 relies on a wheelchair pushed by staff for locomotion and requires full staff assistance for transfers in and out of the chair. Per observation of the home's video recordings during the on-site investigation conducted on 5/7/25 and review of audio recorded interviews with Staff #1 and Staff #2 conducted by the Attorney General's Office (AGO) on 5/6/25, on the morning of 4/24/25 the Manager of the home failed to ensure Resident #1's right to refuse care by forcefully and aggressively attempting to provide nail care despite the Resident repeatedly expressing refusal of this care. Resident #1's refusal of care was evidenced by the Resident striking the dining room table where the care was being provided, pulling back their hands from the Manager as they attempted to perform this care, and the Resident's verbal expressions while positioned in their wheelchair at the dining room	R363	1. Statement of Compliance: Effective immediately, the facility affirms that all residents have the right to refuse care at any time. Staff are prohibited from forcing, coercing, or pressuring residents to accept care against their will. 2. Policy Revision and Implementation: The Resident Rights policy has clear language on the right to refuse care. The policy outlines that staff must: • Respect the resident's decision • Assess and document the refusal • Notify appropriate personnel (e.g., nurse, administrator) for follow-up if necessary • Continue to offer care respectfully without coercion 3. Staff Training: All staff have received training in orientation and each months in service on: • Resident rights, including the right to refuse care • Appropriate communication techniques and response to refusals • Documentation and reporting procedures when care is declined • De-escalation strategies and resident-centered care approaches	**5/7/25**

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R363	Continued From page 16 table to receive this care and during the Manager's attempts to remove the Resident's nail polish. Per observation of the home's video recordings on 5/7/25 and review of audio recorded interviews with Staff #1 and Staff #2 on 5/6/25, the Manger responded to Resident #1's resistance to care in a manner that was physically and verbally abusive towards the Resident including yelling at the Resident to "shut the f--k up", shoving a chair towards the table where the Resident was seated, forcefully and aggressively moving the Resident's wheelchair, and grabbing the back of the Resident's neck. After multiple attempts to provide nail care as the Resident resisted, the Manager wheeled the Resident to their assigned room, exited the room and closed the door. The Manager returned several minutes later, re-entered Resident #1's room, and closed the door. Per review of a personal audio recording documented by Staff who witnessed this incident on the morning of 4/24/25, while the Manager was alone in the room with Resident #1 behind a closed door the Resident can be heard screaming loudly using words identified as "Help", "No", "Stop" and "Get out". Per the 5/6/25 AGO interview, the Manager stated to Staff #1 and #2 that they were performing nail care while they were alone with Resident #1 with the door closed. On the afternoon of 5/7/25 the Owner of the home acknowledged the Manager's failure to ensure Resident #1's right to refuse care.	R363	4. Monitoring and Enforcement: The Administrator/designee will observe staff interactions with residents and review documentation to ensure compliance. Any instance of forced care will be investigated immediately and addressed through disciplinary action and retraining. 5. Resident and Family Education: Residents and their representatives have been informed with admission of the residents right to refuse care through the Resident Rights document upon admission and families are updated as/ when necessary based on residents disease progression. 6. Responsible Party: Administrator/Designee 7. Completion date: Tag 363 is accepted on 5-23-25 by LTCM	5/30/25