VERMONT

**Department of Disabilities, Aging and Independent Living**
**Division of Licensing and Protection**
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

*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

October 28, 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 **October 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

| 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 10/07/2025 |

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

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| R100 | Initial Comments<br><br>On 10/7/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of 2 complaints. The following deficiencies were identified: | R100 | Corrective actions for all deficiencies cited accepted by Jo A Evans RN on 10/28/25.<br><br>Please see the attached document to review the accepted corrective actions. | |
| R145 SS=F | 5.6.c Special Care Units<br><br>A home that has received approval to operate a special care unit must comply with the specifications contained in the request for approval. Failure of the home to provide the services, staffing, training and physical environment as outlined in the request for approval will be the basis for the imposition of sanctions up to and including closure of the unit.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and review of the staff schedules for August, September, and October of 2025, there is a failure to comply with the staffing specifications identified by the operator of the home. During the investigation it was identified the Receiver of the home was unavailable and a designee had been appointed. Findings include:<br><br>Per record review the home is licensed to operate as a 13 bed Dementia Special Care Unit. Per review of documentation provided to the licensing agency by the home's operator states, the staffing specifications for the Dementia Special Care Unit will have a minimum of two caregivers on duty at all times per agreement with the Licensing agency date April of 2021.<br><br>At 11:29 AM on 10/7/25 the Designee of the home was requested to provide staff schedules for the months of August, September and | R145 | | |

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| R145 | Continued From page 1<br>October 2025. Per review of the staff schedules provided by the Designee, only one staff member was on duty at the home during shifts in August 2025, September 2025, and the first week of October 2025.<br><br>During an interview commencing at 2:07 PM on 10/7/25, the Manager listed on the license of the home confirmed there are times when the home is single staffed. At 2:39 PM on 10/7/25, the Designee confirmed there have been multiple shifts during which there was only one staff member on duty at the home during August, September, and the first week of October of 2025. | R145 | | |
| R161 SS=F | 5.9.c (4) Nursing Services<br><br>For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must:<br><br>Provide instruction and oversight to all direct care personnel regarding each resident's health care needs and nutritional needs. Delegate nursing tasks as appropriate, following the Board of Nursing?s recommended practices, with adequate documentation of delegation;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the Registered Nurse responsible for nursing oversight of the home failed to instruct and delegate nursing tasks to the home's Direct Care Staff. Findings include:<br><br>The policies and procedures on site and available | R161 | | |

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| R161 | Continued From page 2<br>for review at the home on 10/7/25 do not identify the Registered Nurse's responsibility for providing instruction and oversight to Direct Care staff to ensure competencies in the nursing tasks staff are expected to perform.<br><br>Per review of training records and checklists, documenting Direct Care Staff competencies provided by the Designee for review on request, the home's Manager listed on the license is responsible for providing training in nursing skills including personal care and hygiene, transfers, toileting, checking vital signs, administration of supplemental oxygen, application of topical medications, and putting on/taking off TED hose to staff.<br><br>Per interview at 2:18 PM on 10/7/25, the Manager confirmed they are responsible for training Direct Care Staff to perform nursing skills; and confirmed they sign off as the "Trainer" on applicable forms to document the training in nursing tasks they provide to staff. The Designee confirmed the home's Direct Care Staff receive training in the nursing skills they are expected to perform by staff other than a Registered Nurse. | R161 | | |
| R170 SS=F | 5.9.c (13) Nursing Services<br><br>For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must:<br><br>Ensure that direct care staff follow current professional standards of practice and current infection control standards during provision of services; | R170 | | |

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| R170 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview there is a failure to ensure Direct Care Staff follow the current professional standards in response to staff member and a resident (Resident #1) testing positive for COVID -19. Findings include:<br><br>The home's Infection Control/Universal Precaution policy states. "It is the policy of [the organization that manages the home] that employees utilize universal precautions to decrease the risk of transmission of infections diseases ...". The home's infection control policies related to COVID -19 have not been updated since 6/12/2020 and are not consistent with the current professional standards of practice.<br><br>Per observation on the morning of 10/7/25, a sign posted on the exterior door indicating the home was a COVID positive environment. On entrance to the home's foyer, a Staff member reported that one of the home's residents (Resident #1) was currently COVID positive. Upon entering the home and throughout the on-site investigation on 10/7/25, Resident #1 was observed without a mask in close proximity to other residents without staff attempting to limit exposure to other residents . Per record review, Resident #1 tested positive for COVID on 10/2/25. Per record review and interview with the Designee, surveillance testing had been conducted once for all the residents of the home as of 10/7/25. Current Vermont Department of Health (VDH) standards for surveillance testing indicate residents and staff are to be tested on Days 1, 3, and 5 after a staff or resident in the home tests positive for COVID. | R170 | | |

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| R170 | Continued From page 4<br><br>Direct Care Staff, including the Designee, were observed to not be wearing masks throughout the investigation on 10/7/25. Per review of the Interim Guidance for Management of Healthcare Personnel with Suspect or Confirmed Viral Respiratory Illness issued by VDH effective September 2025, the current infection control standard is for asymptomactic healthcare personnel with a known or suspected exposure to wear source control from the first day of exposure through the fifth day after their last exposure. Per record review and interview with the Desginee on the afternoon of 10/7/25, the staff employed at the home are scheduled for shifts at multiple Residential Care Homes owned by the some organization. Staff failure to wear masks at the home in response to a known exposure poses a risk for exposure and infection to the residents who reside at all Residential Care Homes owned by the same organization.<br><br>On the morning of 10/7/25, the Designee confirmed the home had not contacted the Vermont Department of Health (VDH) regarding the COVID positive case. On the afternoon of 10/7/25 the Designee then stated VDH had been contacted; however, documentation supporting this statement was not provided on request. Per review of the Vermont Department of Health's Reportable and Communicable Disease Rule effective 8/10/2024, Registered Nurses and Administrators of Long Term Care and Assisted Living Facilities are required to report all positive, presumptive positive, confirmed, isolated, or detected cases of COVID-19 infection to the Vermont Health Department.<br><br>During the investigation process and during exit on the afternoon of 10/7/25, the Designee acknowledged the finding of a failure to report to | R170 | | |

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| R170 | Continued From page 5<br>VDH, to perform surveillance testing, and to implement infection control measures including the staff wearing masks according to current professional standards. | R170 | | |
| R349 SS=F | 6.1 Resident's Rights<br><br>Every resident must be treated with consideration, respect and full recognition of the resident ' s dignity, individuality, and privacy. Care provided to residents must be person-centered. A home may not ask a resident to waive the resident's rights.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and record review there is a failure to treat residents of the home with dignity and respect for individual abilities related to care planning by the home's Nursing staff and Direct Care Staff's response to resident needs, behaviors, and symptoms of mental illness and cognitive impairment. Findings include:<br><br>The home's Written Behavior Plan form states, "Residents with dementia often execute challenging behaviors" and identifies non-pharmacological steps for responding to resident's behavioral needs including, "Never correct, Always redirect", "try a little one on one to see if you can calm them down", "an empathetic ear", and "tell them that you want to help them because you are their friend".<br><br>The following examples of failure to treat 3 of the home's residents (Resident #1, Resident #2, and Resident #3) with dignity and respect were | R349 | | |

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| R349 | Continued From page 6<br>observed during the investigation conducted on 10/7/25:<br><br>1. Resident #1's diagnoses include a history of a Cerebrovascular Incident with associated right sided weakness, memory imapirment and mental health diagnosis's. This Resident uses a wheelchair for mobility and requires staff assistance with Activities of Daily Living including toileting. Resident #1's Care Plan indicates Resident #1 experiences urinary and bowel incontinence and includes a 'Management Plan" which states "toilet every 2-3 [hours], will ask to go every ½ hour - set limits". The Behavior/Cognitive Skills section of Resident #1's Care Plan describes this Resident as "Noisy", Uncooperative", Irritable" and "Confused"; and states Resident #1 "tends to be demanding".<br><br>On the afternoon of 10/7/25 Resident #1 was observed to have difficulty expressing thoughts verbally, and was able to answer yes /no questions using both verbal expression and nodding of their head. During an interview commencing at 3:00 PM on 10/7/25, Resident #1 indicated they are able to transfer from wheelchair to toilet independently at times; and indicated a staff members who recently stopped working at the home would sometimes say no when they needed assistance toileting and indicated they were treated poorly by staff. During an interview commencing at 2:07 PM on 10/7/25, the Manager confirmed the Care Plan on file for Resident #1's which includes instructions to limit staff assistance with toileting has been in effect since their employment with the home.<br><br>2. Resident #2's Care Plan lists mental health diagnoses characterized by excessive thirst and drive to consume fluids without physiological | R349 | | |

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| R349 | Continued From page 7<br>need for increased fluid intake such as dehydration. This condition results in increased urination, and is a risk for fluid/electrolyte imbalances.<br><br>Per interview commencing at 2:07 PM on 10/7/25, the Manager of the home stated Resident #2 has a history of consuming large amounts of beverages and food, then vomiting. Per record review, Resident #2's Care Plan states "limit caffeine/sugar" and "limit fluid intake will vomit". This plan does not include goals and specific interventions developed by the Registered Nurse to ensure consistent response to Resident #2's requests for additional foods and beverages with consideration for the Resident's medical and nutritional needs, and resident's rights. When the Manager was asked how staff are expected to respond when residents request additional servings of foods and beverages, the Manager stated if there is a concern about a resident throwing up they are asked to wait a while, given "a little something" if they continue to request more, and told how long the wait is until the next meal.<br><br>During lunch service on the afternoon of 10/7/25 Resident #2 was observed requesting additional servings of food and beverages. Staff were observed responding by saying no, telling Resident #2 the amount they had already consumed, expressing concern the resident would throw up, and giving the Resident items other than what they had requested. After not receiving a requested beverage, Resident #2 was observed telling the Staff they had something in their throat, and was told by the Staff that if they had something in their throat they would be coughing. | R349 | | |

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| R349 | Continued From page 8<br><br>Resident #2's Care Plan includes statements indicating:<br>a. Speech is normal "unless trying to get self worked up then mumbles"<br>b. Behavior/ Cognitive Skills are "Noisy" and "Irritable" with a section labeled as "Plan" that states Resident #2 has a history of making suicidal comments for attention and when not getting their way.<br>c. The Decision Making section of this Care Plan states Resident #2 "purposely attempts to irritate staff and residents" and "tries to use aggression/combative to get their own way".<br><br>3. Resident #3 is diagnosed with memory impairment and Generalized Weakness. Resident #3's Care Plan describes their Behavior/Cognitive Skills as "Noisy", "Uncooperative" and "Confused" ; and indicates their ability to make decisions is severely impaired.<br><br>From 3:59 PM - 4:03 PM on 10/7/25 Resident #3 was observed yelling out for help while seated in their wheelchair in the open doorway of their room. During this time period, Direct Care Staff and the Designee were observed standing in the kitchen doorway within hearing distance and with a clear in line of sight to Resident #3; and were observed looking in the direction of Resident #3's doorway without responding to the Resident repeatedly yelling out for help.<br><br>On the afternoon of 10/7/2, the Designee confirmed staff responses to resident's needs and the content of resident care plans on file at the home were identified as deficiencies. | R349 | | |

## Deficiency Statement Plan of Correction (POC)

**Survey Date:** 10/7/2025

**Facility Name:** Our House Too

| Deficiency Tag | How the deficiency was corrected | How other potential residents identified, and corrective action taken | Date corrected | System changes to ensure compliance of the regulation | Who will monitor to ensure compliance |
|---|---|---|---|---|---|
| R145 | Receiver reviewed schedules and | no specific residents identified | 10/24/25 | Receiver contracted with Travel | Receiver |
| | timecards to verify staffing | | | agency to provide temporary staff on 10/13/2025. | |
| | levels at the center to ensure | | | Consolidation of residents has allowed | |
| | 2 caregivers are present on all | | | for appropriate staffing due to staff | |
| | shifts. | | | consolidation 10/17/2025 | |
| | Plan of Correction for | R145 accepted by Jo A | Evans on | 10/28/25 | |
| | | | | | |
| R161 | Policy for RN delegation created. RN | no specific residents were | 10/29/25 | Create RN Delegation policy and provided | Receiver |
| | and managers trained on new | identified | | Training to the RN's regarding | |
| | policy on 10/29/2025. | | | their responsibilities. Updated training | |

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| | Removed managers as responsible | | 10/31/2025 | checklist to identify who is responsible | |
| | for providing training on | | | for each training topic. | |
| | Nursing skills. RN is | | | | |
| | responsible for training staff | | | | |
| | on nursing skills. | | | | |
| | | | | | |
| | Training checklist updated | | 10/31/2025 | | |
| | to identify who is responsible | | | | |
| | for training each topic. | | | | |
| | Plan of Correction | for R 161 accepted by Jo A Evans | | RN on 10/28/25 | |

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| R170 | Covid policies were updated | no Residents were impacted | 10/29/2025 | Policy changes | Receiver |
| | to reflect current standards of | (tested positive for Covid) | | audits | |
| | practice including masking, | | | education | |
| | reporting requirements and | | | | |
| | surveillance testing. | | | | |
| | Receiver reported Covid cases | | | | |
| | and completed line list to VDH on | | | | |
| | 10/13/2025 | | | | |
| | Masking audits were completed | | | | |
| | by RN's and receiver. | | | | |
| | Education provided to staff | | | | |

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| | on Covid standards on | | | | |
| | 10/29/2025 | | | | |
| | Plan of Correction for R 170 accepted by Jo A Evans RN on 10/28/25 | | | | |
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**Survey Date: 10/7/2025**

**Facility Name: Our House Too**

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| R349 | Careplans for residents 1,2,3 | Receiver audited Resident | 11/12/25 | updated Care plan format and policy | Receiver |
| | updated to reflect current | records to identify other | | Staff education on Resident Rights | |
| | behavioral concerns by 10/31/2025 | residents who may have been | | Interview of current residents | |
| | | impacted. Care plans updated as needed. | | | |
| | Staff education on Resident | | 10/29/25 | | |
| | Rights, dignity and respect and | | | | |
| | timely response to resident | | | | |
| | requests. | | | | |
| | | | | | |
| | Receiver interviewed current | | 11/10/25 | | |

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| | residents who were able to | | | | |
| | participate regarding staff | | | | |
| | treatment. | | | | |
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| | Care plan format revised to | | 10/31/25 | | |
| | include goals and interventions | | | | |
| | which are developed by RN's | | | | |
| | Plan of Correction for R 349 accepted by Jo A Evans RN on 10/28/25 | | | | |
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