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

February 9, 2026

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 **January 20, 2026.** 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 01/20/2026

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 1/20/2026 the Division of Licensing and Protection conducted 2 unannounced on-site follow-up surveys to determine if the home was back in compliance with the Vermont Residential Care Home and Assisted Living Residences Licensing Rules related to 2 deficiencies cited on 11/17/2025; and 2 deficiencies subsequent to a follow up survey conducted on 7/15/2025 which were initially cited on 5/7/2025. During the follow-up surveys conducted on 1/20/2026 the home was determined to be back in compliance with the Vermont Residential Care Home and Assisted Living Residences Licensing Rules for both follow-ups. In addition to the follow-up surveys conducted on 1/20/2026, the Division of Licensing and Protection also conducted an unannounced on-site investigation of one facility reported incident during which the following deficiencies were identified:	R100	Plan of Correction accepted by Jo A Evans RN on 2/9/2026 Please see the attached document to review the corrective actions for the deficiency cited.	
R360 SS=D	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 staff interview and record review there is a failure to ensure one applicable resident (Resident #1) remained free of physical abuse by another resident (Resident #2). Findings include: The home's polices and procedures are consistent with this licensing rule.	R360		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Helen Bishop manager OHToo 2/5/26

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R360	Continued From page 1 Per record review, Resident #1's diagnoses include mental health and is dependent on the use of a wheelchair for mobility and has difficulty communicating verbally. Resident #1 demonstrates protective behaviors and has a history responding to other residents' behaviors by attempting to intervene. Per record review, Resident #2 is living with cognitive impairment and frequently wanders throughout the home and takes items belonging to others without awareness or understanding of the impact of their behavior on other residents. Residents #1 and #2 have a history of conflict including altercations during which Resident #1 has demonstrated aggressive and abusive behaviors towards Resident #2. Both Resident's Care Plans identify this issue, and include goals and interventions to address needs related to the applicable Residents' behaviors, and staff monitoring to prevent altercations. Per interview with the Manager commencing at 1:42 PM on 1/20/26, and per review of information reported to the licensing agency, throughout the morning of 1/4/26 Resident #2 demonstrated agitation and confusion. Resident #2 was heard yelling "get out" when no one was present in their room, observed throwing items from their room into the hallway, and was not easily redirected. Per review of video surveillance footage, staff interviews, and record review, at approximately 12:10 on 1/4/26 Resident #2 entered the home's living room and took a blanket off a resident who was resting in a recliner. When this occurred Resident #1 was seated in their wheelchair in the sunroom adjacent to the living room with another resident and visitors. Resident #2 entered the sunroom carrying a blanket; walked towards Resident #1	R360		

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R360	Continued From page 2 and the visitors while shaking their finger at the group, then advanced towards Resident #1. Per review of video surveillance footage, and record review, both Residents briefly had ahold of the blanket, then Resident #1 grabbed and pulled at Resident #2's lower arm and wrist with force and pressure that broke a metal link charm bracelet worn by Resident #2. During the interview commencing at 1:42 PM on 1/20/26 the Manager stated they responded after Resident #2 had released their hold on Resident #1's arm; and stated after the incident one of the visitors informed them that Resident #2 told the group to get out of the room, and the physical interaction between the Residents occurred when Resident #1 expressed they did not have to leave. During an interview commencing at 11:30 AM on 1/20/26 the court appointed Receiver confirmed Resident #2 was physically abusive towards Resident #1 during the incident that occurred on 1/4/2026. The finding of the home's failure to ensure Resident #1 remained free of abuse by Resident #2 was acknowledged by the Manager and Receiver during the exit conference conducted on the afternoon of 1/20/26.	R360		

Deficiency Statement and Plan of Correction (POC)

Survey Date: 1/20/2026

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
R360	The residents were separated.	No other residents were impacted	2/14/26	Staff education provided regarding "Understanding Behavior as Communication"	Manager, Receiver
				Manager or designee to begin each day with a reminder to Resident #1 to request staff assistance when needed.	R360 accepted by Jo A Evans RN on 2/9/2026