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

May 25, 2021

Ms. Beth Peer, Manager
Our House Outback
196 Mussey Street
Rutland, VT 05701-4839

Dear Ms. Peer:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 23, 2021.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

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
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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 on-site investigation of two complaints was conducted, in conjunction with a facility reported incident investigation, by the Division of Licensing and Protection on 2/3/2021, followed by an extended unannounced on-site investigation on 2/10/2021, concluding after further offsite review & interviews, on 2/23/2021. There were regulatory deficiencies identified as a result of the investigations which resulted in the need for Immediate Corrective Action to be taken by the facility.	R100	As per the directed plan of care to be completed by 6/1/21 and audits ongoing.	
R127 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.b Staff shall provide care that respects each resident's dignity and each resident's accomplishments and abilities. Residents shall be encouraged to participate in their own activities of daily living. Families shall be encouraged to participate in care and care planning according to their ability and interest and with the permission of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that staff provided individualized care based on specific cognitive and behavioral needs of a Resident with dementia, for one of four residents (Resident #1) in the applicable sample. Findings include: 1. Per record review, Resident #1 has a diagnosis of Dementia. The Written Behavior Plan dated 8/6/19 and reviewed by the facility RN on	R127	It is understood that per R127, Staff shall provide care that respects a resident's dignity... To that end, Nurse-led education will be provided currently and repeated annually to all caregivers that every resident's care plan shall be updated to include changes in residents' needs and/or abilities to provide and/or receive care. ***What action you will take to correct the deficiency*** An audit of all resident's care plans and behavioral plans will be conducted immediately by the nurse, to ensure all resident-specific behaviors are adequately addressed and there are resident-specific interventions that work with each resident's abilities in order to provide care that respects each resident's dignity. Direct care staff will be consulted during this process, as they are aware of each resident's abilities and the challenges in the day-to-day care of the resident. Staff will be trained on resident-specific interventions and will be trained on how to document and notify the nurse of any changes in resident abilities or need to alter interventions.	

R127-R266 Directed POC's accepted 5/13/21 – P.Cota RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R127	Continued From page 1 7/31/2020, list anxiety, agitation, and exit seeking as behaviors. Interventions identified are reassure her/him that s/he is safe, assess respiratory status, redirect, allow to wander, encourage going to her/his room to have quiet time, call for PRN (an as needed medication). Per a Facility to Nurse Note written by a Med Tech on 10/3/2020, the Resident was noted to be leaving "Chunks of his BM around [her/his] room. On night stand, the floor, and behind [her/his] closet". The Registered Nurse (RN) response was to "rearrange room to try to prevent, and direct to the bathroom". This behavior is not addressed on the Behavior Care Plan, nor where these interventions added to the Behavior Plan. Resident #1 was noted to have BM on her/his hands and clothes on 11/28/2020 and 1/25/2021, becoming violent with staff while they were assisting. During these incidents, the listed interventions for anxiety and agitation were not followed by staff. Resident #1's Behavior Plan was not updated to reflect this behavior, nor was a plan in place that identified appropriate interventions for staff to prevent escalation when assisting the Resident when soiled with BM. Per interview with the House Manager on 2/3/2021 at 4:30 PM, s/he confirmed that Resident #1 had a history of these behaviors and that s/he had spoken with the Med Tech after the 11/28/2021 incident about approaching the Resident in a different way, or re-approaching at a later time. S/he also spoke to both staff members involved about "reading signs that the Resident was uncomfortable, not waiting till its at that point, and not calling [the resident] out on having BM on [her/him]. [S/he] wouldn't get mad if you didn't say 'you have BM on you'." However, the Behavior Plan was not updated to reflect these specific approaches.	R127	***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*** Care plans and behavioral plans will be reviewed by the nurse at least quarterly. Direct care staff will be interviewed during the review of the care plan/ behavioral plan to ensure any new or evolving issues are addressed. ***How the corrective actions will be monitored so the deficient practice does not recur*** To ensure care is being delivered that respects each resident's dignity and abilities: The nurse and Manager of the home will review resident records and observe residents' abilities and challenges at least weekly, as well as the interventions direct care staff use to provide care and redirection during various times of day and to capture staff on each shift. If any needs around staff training are identified, any necessary education/training will be provided as soon as possible and documented. Once the nurse and Manager have determined needs are stable and staff are competent, reviews can shift to quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R127	Continued From page 2 Per phone interview with the Med Tech on 2/10/2021 at 11:49 AM, s/he stated that Resident #1 "did not like [her/him]. I could be a foot away from the [Resident] and [s/he] would start grabbing me". The Med Tech also confirmed that the Resident was frequently found with BM on her/his hands, and that s/he "did not know what to do" to prevent the Resident from becoming aggressive. Refer also to R145, R146 and R178.	R127		
R132 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.5 Special Care Units 5.6.c A home that has received approval to operate a special care unit must comply with the specifications contained in the request for approval. The home will be surveyed to determine if the special care unit is providing the services, staffing, training and physical environment that was outlined in the request for approval. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review the facility failed to comply with the specifications detailed in their application to operate a special care unit. Findings include. 1. Per review of the facility special care unit application dated February 1, 2010, that was submitted to, and approved by the licensing agency, "There will be three shifts. There will be 12 hours per day when there are two caregivers	R132	It is understood that per R132.1, that approved special care units must be particularly staffed. As we continue to recruit and train new staff, we will encourage the use of outside agencies who provide LNA and Nursing care for our Hospice-approved residents to assist us in the care of our residents and families. Additionally, Nurse-led dementia education has been added to our Orientation process which will be completed prior to any new staff beginning work with our residents. This training will be repeated at least annually. So that all of our staff have the same knowledge, our Nurses shall be providing Dementia care to each care giver. This education will be completed by June 1, 2021. At least annually, the Administrator shall query an audit of this education of which records shall be kept. ***What action you will take to correct the deficiency*** The facility will implement the Special Care Unit plan as attached. See attached Special Care Unit Directed Revision. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*** At least quarterly, the Manager will review the elements of the SCU plan and ensure training/ documentation are complete. ***How the corrective actions will be monitored so the deficient practice does not recur*** The Manager will monitor for ongoing compliance.	June 1, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R132	Continued From page 3 on duty and 12 hours per day when there will be three care givers on duty". Per review of the 1/30-2/12/2021 staffing schedule, there are only two staff members on per shift, for all 42 shifts. During an interview with the Registered Nurse (RN) on 2/3/2020 at 10:30 AM, s/he confirmed that there are two staff members on day, evening, and night shifts, one is a Med Tech. The RN stated that "A manager is here often as well". However, in review of the 1/30/2021-2/12/2021 schedules, the House Manager is on the schedule as the second caregiver on the 2/1, 2/8, 2/9, and 2/11/2021 evening shifts, and 4:00 PM-2:00 AM on 2/3/2021. During an interview on 2/10/2020 at 4:00 PM, A Med Tech confirmed that the 1/30 - 2/12/2021 schedules provided for review were actual staffing schedules. Per phone interview on 2/23/2021 at 11:45 AM, the facility Owner confirmed that there are only 2 staff members scheduled each shift. S/he stated "We can't find the help. If we could we would have them. Managers are now on the schedule 3 shifts a week". During a phone interview with the facility Manager on 2/23/2021 at 12:40 PM, s/he stated that there have been 2 staff members scheduled on each shift since at least September when s/he started there. 2. The facility special care unit application states, "In addition to our expected 12 hours of in-service education we will train our staff on dementia, with a focus on Alzheimer's disease. Training will be both OTJ (on the job), as well as 10 annual hours of classroom training on Alzheimer's and other types of dementia". During an interview with the facility Manager on	R132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R132	Continued From page 4 2/3/2021 at 4:30 PM, there is no documented evidence that additional education is being provided. The Manager stated "I used to be better about having it documented, but not recently". During a phone interview on 2/10/2021 at 11:49 AM, a Med Tech who has been the recipient of several incidents of aggression by Residents in her/his care, stated "I don't know how to react, I get into protection mode. I don't know what to do". When asked by this Surveyor if s/he feels that s/he has enough training to care for Residents with difficult behaviors s/he stated "I have been talked to by [the Owner]" and " I get lectures of 'It's your approach' is all I get". When asked if management and staff ever had meetings as a group to discuss approaches that work with specific Residents, the Med Tech stated "No, but my coworkers and House Manager do help me with it. I've asked them that if they need to, to tell me to back off". During a phone interview on 2/23/2021 at 4:30 PM, the Med Tech also stated that the monthly mandatory staff meetings are mostly staff [complaining] about others, but s/he does do the independent training with quizzes. Per phone interview with the facility Owner on 2/23/2021, at 11:50 AM, a lot of the training staff gets is on the job. There are monthly meetings with inservices, and monthly independent trainings. New staff are trained on resident rights, APS (Adult Protective Services) and other mandatory things. The Owner confirmed that there is no documented minutes of the meetings to reflect 10 hours of additional classroom training annually as stated in the special care unit application. 3. Per review of the facility document titled	R132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R132	Continued From page 5 "Please Take One" that describes the facilities philosophy, and was included in the facility special care unit application, "Our job is to comfort the individual, we DO NOT correct someone unless they ask us to, we DO NOT force people into activities of daily living; we rather encourage them at their own pace". Per review of a statement dated 11/28/2020 and signed by a Med Tech and a caregiver, the Med Tech noticed that Resident # 1 had bowel movement (BM) on her/his clothing and on their hands. The Med Tech stated in the report that "I asked [Resident # 1] to come with me and we went into the bathroom. I explained to [her/him] about the BM and that [s/he] needed to get changed and wash it off of [her/him]. I tried to get [the Resident] to stay in the bathroom and let [her/him] know how unhealthy that is". Per the statement, Resident #1 then became combative. The other staff member on duty came in, and per the statement "Again we both tried to let [the Resident] know about the BM". Resident #1 became combative again and the Med Tech states that s/he "did push [the Resident] off of me twice. [the two staff members] hooked [their] arms under [the Resident's] arms- like we would when we lift a resident - to help her/him calm down and stop hitting. Both [staff members] understand not fighting with the residents But this was a very concerning health situation". Per interview with the facility Manager on 2/3/2021 at 4:30 PM s/he was not on duty at the time of the 11/28/2020 incident. When s/he came back after the weekend, s/he spoke with both staff members involved in the incident. S/he explained that they should be "reading signs that [the Resident] was uncomfortable, and not waiting till its at that point. Not calling [the	R132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R132	Continued From page 6 Resident] out on having BM on [her/him]. [The Resident] wouldn't get mad if you didn't say 'you have BM on you'." When asked if s/he thought that Resident #1 would have become aggressive if the Med Tech had used a different approach, s/he stated "no". Per phone interview with the Med Tech on 2/10/2021 at 11:49 AM, s/he has been working at the facility for about two years. S/he stated that when Residents experience behaviors "It's hard to back off most of the time". S/he also stated "I don't know how to react. I get in protection mode and I don't know what to do. They tell me not to confront".	R132		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the RN failed to complete an accurate annual assessment for one of five residents (Resident #1) in the applicable sample. Findings include: Per record review an annual assessment dated 12/20/2020 states that Resident #1 has never been physically abusive. However, an Incident	R136	It is understood that per R136, each resident shall be assessed annually and whenever changes occur. To that end, we will provide education and support to our Nurses so that they will review resident care plans annually and whenever changes occur. Moreover, the Nurses shall provide education (with date and signature) to all Care Givers working with that resident at least annually, but whenever changes occur. ***What action you will take to correct the deficiency*** Resident #1 is no longer at the facility, so cannot correct for the cited resident. The RN or Manager will audit each resident's assessment to ensure it has been completed annually and with significant changes in physical or mental condition. The RN will complete all assessments identified as missing, inaccurate or incomplete. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*** The home will track when annual resident assessments are due, and the RN will complete assessments prior to or on the due date. The home will establish a mechanism for communicating with the RN when there has been a sustained change in a resident that warrants a new assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R136	Continued From page 7 Report completed on 11/28/2021 includes a statement written and signed by two staff members on duty at the time of the incident. The statement states that Resident #1 was grabbing and scratched a Med Tech, then became more violent kicking both staff members. During this incident Resident # 1 bit Med Tech #1's shoulder. During an interview with a Med Tech on 2/9/2021 at 12:30 PM s/he confirmed that Resident #1 did not like Med Tech #1 and exhibited physically aggressive behaviors towards her/him. Per interview with the Med Tech #1 on 2/10/2021 at 11:49 AM, s/he stated that Resident #1 would "hit or grab me, I could be a foot away from [Resident #1] and s/he would start grabbing and flinching". According to Med Tech #1, becoming aggressive toward her/him was a common behavior for Resident #1. Per interview with the House Manager on 2/3/2021 at 4:30 PM, s/he confirmed that Resident #1 had a history of being physically aggressive to Med Tech #1.	R136	***How the corrective actions will be monitored so the deficient practice does not recur*** The Manager will audit resident assessments at least quarterly to ensure they are completed annually and/or with sustained change in abilities It is understood that per R145 a written care plan must be written for each resident. In that light, resident care plans shall be updated by the Nurse when necessary to reflect changes in behavior patterns. The Nurse shall then educate care givers of said change(s) documented on the written behavior plans and care plans. RNs will monitor and audit each other monthly for compliance. ***What action you will take to correct the deficiency*** An audit of all resident's care plans and behavioral plans will be conducted by the nurse immediately, to ensure all resident-specific behaviors are adequately addressed and there are resident-specific interventions that work with each resident's challenges and abilities in order to provide quality behavioral care. Direct care staff will be consulted during this process, as they are aware of each resident's abilities and the challenges in the day-to-day care of the resident. Staff will be trained on resident-specific interventions in each resident's care plan and will be trained on how to document and notify the nurse of any changes in resident abilities or need to alter interventions.	
R145 SS=J	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;	R145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R145	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review the Registered Nurse (RN), failed to ensure that each Resident's care plan described the care and services necessary to maintain well being for 2 applicable residents (Resident #1 and Resident #2). Findings include: 1. Per record review, Resident #1 was admitted on 8/8/2018 with a diagnosis of dementia. Per a 'Facility to Nurse Note' written by a Med Tech and dated 10/3/2020, the Resident was leaving "chunks of BM around [her/his] room". Incident Reports dated 11/28/2020 and 1/25 2021 refer to the Resident being found by staff with BM on her/his hands and clothes, and becoming resistive and combative to staff. The Resident Care Plan, reviewed by the RN on 7/31/2020, indicates that Resident #1 is incontinent of bowel and bladder, with interventions to; Discourage from voiding in room and outside, and toilet -remind. The Written Behavior Plan also reviewed by the RN on 7/31/2020, lists Anxiety, agitation, and exit seeking as behaviors. Planned interventions are to "reassure [her/him] [s/he] is safe, assess respiratory status and treat if indicated, redirect, allow to wander, encourage going to [her/his] room to have quiet time, Call RN for PRN'. Neither the Resident Care Plan or the Written Behavior Plan reflect that Resident #1 removes her/his BM with hands, or that s/he becomes resistive and combative with staff during care. There are also no resident-centered, specific interventions listed in either plan for this resident, based on a behavioral assessment, discussions with the care team, and observations of the resident to assist staff in managing these specific individual behaviors. Behavior	R145	***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*** Care plans and behavioral plans will be reviewed by the nurse quarterly. Direct care staff will be interviewed during the review of the care plan/behavioral plan to ensure any new or evolving issues are addressed in the resident-specific interventions. ***How the corrective actions will be monitored so the deficient practice does not recur*** To ensure care plans are resident-specific and based on each resident's abilities and needs: The nurse and Manager of the home will review resident records and observe residents' abilities and any care or behavioral challenges at least weekly, as well as the interventions direct care staff use to provide care and redirection during various times of day, and to capture staff on each shift. If any revisions are needed to resident plans of care, they will be made immediately and any necessary education/training will be provided as soon as possible and documented. Once the nurse and Manager have determined needs are stable and staff are competent, reviews can shift to quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R145	Continued From page 9 management for individuals with aggressive, resistive, or not easily redirectable behaviors is part of the nursing care of this resident which is required to be overseen by a RN. On 2/10/2021 at 11:49 AM, during a phone interview, a Med Tech confirmed that s/he did not know what to do when Resident #1 became aggressive, and that s/he had not been aware of effective techniques to use when dealing with her/him. On 1/25/21, the resident did not receive effective behavioral management from the onsite, unlicensed staff present at the time and became very agitated and aggressive, resulting in a fall with a head injury, causing her/him to pass away on 1/27/21. 2. Per record review, Resident #2 was admitted on 1/8/2021 with diagnoses of Dementia with Behaviors and Chronic Back Pain. The referral packet from the hospital indicates that Resident #2 had increased behaviors at the Residential Care Home that s/he had resided, and the facility had sent her/him to the hospital during an episode of agitation. Due to these behaviors the facility could no longer care for her/him, and s/he did not return to the facility. Per hospital documentation, due to aggressive behavior, Resident #2 required restraints and Haldol administration while at the hospital. Per an Accident Incident Report dated 1/22/2021, a Med Tech was attempting to get the Resident to sit down with her/his food and the Resident grabbed the Med Tech by the arm and punched her/him in the throat. Per Facility to Nurse Notes written by the Med Tech dated 1/24/2021, the Med Tech was attempting to redirect Resident #2 from sitting in a chair that was occupied by another Resident, when the Resident started to	R145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R145	Continued From page 10 punch the Med Tech. Per a facility Accident Incident Report, on 2/5/2021, Resident #2 was getting physical with a Med Tech, the Resident walked away, then s/he walked up behind another Resident and pushed them to the floor. On 2/6/2021 per a Facility Nurse Note, while being redirected from another Residents room, the Resident hit the Med Tech repeatedly. The Written Behavior Plan signed by the RN and dated 1/20/2021, lists agitation, aggression, increased wandering, enters others rooms, occasionally uses cane to ward others off. The planned interventions include "Remove from situation that is agitating [her/him]. Let [her/him] wander- do not try to stop [her/him]. Talk softly; offer drink. Call RN if unsuccessful". Per a document in the Resident's record titled "To the chart for: [Resident #2]" dated 1/8/2021, staff are instructed to "Read [her/his] personal history interview. [S/he] will likely enjoy walking around and maybe peeking in other residents rooms, do not "correct [her/him], redirect [her/him] as you should always do with our residents". The Written Behavior Plan does not reflect that Resident #2 is physically assaultive to staff, or that s/he has been physically assaultive to other Residents. There are no specific interventions developed by a RN based on a behavioral assessment, discussions with the care team, and observations of the resident in place for staff to implement when Resident #2 is assaultive to others.	R145		
R146 SS=J	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3)	R146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R146	Continued From page 11 Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the RN failed to provide, for unlicensed staff responsible for resident care, adequate behavior management delegation, training and supervision to avoid, prevent, and/or de-escalate aggressive Resident behaviors for 2 applicable residents (Resident #1 and Resident #2). Findings include: 1. Per record review Resident #1 had a history of Resident to Resident and Resident to staff physical aggression. Per Facility to Nurse note and written statement signed by a Med Tech and dated 11/28/2020, Resident #1 had become resistive to care and increasingly violent and combative towards the Med Tech, while being assisted with toileting. Another staff member attempted to intervene causing the Resident to become "more violent". Both staff members "hooked arms under the resident's arms... to help her/him to calm down and stop hitting", essentially restraining the resident. In a response to the Facility to Nurse note dated 11/30/2020, the RN wrote that s/he had received a call from the Med Tech "reporting [Resident #1] had been incontinent of stool, was resisting cleanup. [Med Tech] stated 'Had to be firm with [the Resident] to get [her/him] to cooperate and gently led [her/him] to the bathroom with [her/his] arm under [the Resident's] armpit. [The Resident] finally settled down and allowed care'. Instructed [the Med Tech] to call for a PRN in the future to settle [the Resident] down". There is no evidence that the RN provided the staff members with additional	R146	It is understood that per R146, supervision and delegation must be provided to caregivers by the Nurse after appropriate assessment and care planning. To that end, Nurses shall be trained to review all care plans and medications with each caregiver who is providing care at a particular house. This education shall be provided will be completed by May 1, 2021. Audits of caregivers' knowledge shall be conducted and documented quarterly by Nurse. It is further understood that each plan of care ascertains a resident-specific approach. This approach necessitates knowing as much as possible about any given resident. Nurses shall document in the patient chart that he/she has reviewed all content – particularly of newly admitted patients. This Nurse process shall begin immediately and shall be audited and documented quarterly. ***What action you will take to correct the deficiency*** See facility response above. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The Manager will ensure, via observation and audits, that the nurse has provided instruction, supervision and properly documented delegation for all nursing tasks including behavioral management for each resident. ***How the corrective actions will be monitored so the deficient practice does not recur*** To ensure staff are adequately educated, delegated and supervised: The nurse and Manager of the home will review resident records and observe residents' abilities and challenges at least weekly, as well as the interventions direct care staff use to provide care and redirection during various times of day and to capture staff on each shift. If any needs around staff training are identified, any necessary education/training will be provided as soon as possible and documented. Once the nurse and Manager have determined needs are stable and staff are competent, reviews can shift to quarterly.	May 1, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R146	Continued From page 12 interventions, education, training and supervision to avoid, prevent, or de-escalate Resident #1's aggressive behaviors. Per review of a statement written by a Med Tech, on 1/25/2021 at 5:30 PM, a Med Tech found Resident #1 with BM on her/his hands, leaving a "clump on the piano bench". The Med Tech wrote that the Resident "grabbed my arm. I told [her/him] to let go of me, [s/he] did. I took a step inside the bathroom to get closer to the trash can to throw away the BM. I started to turn and leave and [s/he] grabbed my arm and my back while trying to kick me. I held the doorway to keep myself from falling over. [S/he] wouldn't stop when I asked [her/him] to so I nudged my shoulder back and that's when [s/he] lost [her/his] balance and fell back onto [her/his] right side, hitting [her/his] head on the floor". Per 'Action Taken' statement, the Med Tech wrote that Resident #1 was completely unresponsive for almost 2 minutes. Per a typed note written by the RN, on 1/25/2021 at 5:38 PM s/he received a call from the Med Tech reporting the incident. The RN responded to the facility, and assessed the Resident. Per Nurses Note written by the RN, at 9:55 PM on 1/25/2021, s/he received a call from the Med Tech that Resident #1 was vomiting. The RN then called the ambulance for transport to the emergency room. During evaluation at the hospital, Resident #1 was diagnosed with a Subdural Hematoma as a result of the fall. S/he was admitted to the hospital and died on 1/27/2021. Per interview with the RN on 2/3/2021 at 10:30 AM, s/he is responsible for all of the medication certification but the Owners and Mangers provide other required training. S/he stated "I watch how they interact with others, staff initiative, resident	R146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R146	Continued From page 13	R146		

interaction, and their approach with Residents". However, there is no evidence of specific behavior training by the the RN, or supervision of staff specific to this repeated behavioral issue. Behavior management for individuals with aggressive, resistive, or not easily redirectable behaviors is part of the nursing care of this resident which is required to be overseen by a RN.

During an interview with the House Manager on 2/3/2021 at 4:30 PM, s/he stated that s/he was responsible to provide behavior management training, and s/he had not been documenting these trainings over this year. S/he stated that s/he reviews the incidents and provides staff with specific techniques to manage difficult behaviors based on each incident. The Manager confirmed that there was no documented evidence of any specific training, and also stated that Resident #1 would not have become aggressive if the Med Tech had used a different approach.

Per phone interview with the Med Tech on 2/10/2021 at 11:50 AM, s/he confirmed that s/he did not know what to do when Residents refused redirection or became combative. The Med Tech stated that the Manager and coworkers do provide feedback at times and s/he has asked them to stop her/him if they notice that s/he needs to "back off". S/he also confirmed that s/he had not been given adequate training to manage difficult behaviors.

2. Per record review, Resident #2 has a diagnosis of Dementia with Behaviors and a history of violent aggression prior to, and since admission. A document in the Resident's chart dated 1/8/2021, outlines some details of the Resident's past for staff. It states "don't sweat the small stuff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R146	Continued From page 14 Read her/his personal history interview. [The Resident] will most likely enjoy walking around and maybe peeking in other residents rooms, do not "correct" [her/him], redirect [her/him] as you should always do with our residents". It also states that "Kindness and patience goes a long way". There is no documented evidence that staff have read this document. An Incident and Injury report dated 1/2/2021, reflects that a staff member was attempting to get the resident to sit down and eat her/his meal when the Resident grabbed the staff member by the arm and punched her/him in the throat. Per a Facility to Nurse note written on 1/24/2021 at 6:45 PM, Resident #2 became combative with a Med Tech when s/he was attempting to redirect him/her from sitting on another Resident. The RN response was "Thank you for the update". There is no evidence of suggested approaches, training, or counseling provided to the staff member who was the recipient of the Resident aggression. Per facility Incident Report dated 2/5/2021 at 6:48 PM, Resident #2 was "getting [physical] to a staff member" the Resident then left the area, came back, "walked up behind another Resident [and] pushed to the floor". Per Facility to Nurse note written on 2/6/2021 at 2:40 PM, a Med Tech was attempting to redirect the Resident from other Resident's rooms when s/he began to repeatedly hit the Med Tech, leaving a bruise on the Med Tech's arm. The documented RN Response was "Please be careful if [she/he] is agitated give [her/him] space". During an interview with a facility Co-Owner on 2/3/2021, s/he stated that it has been difficult to provide education to staff due to COVID. They have had to limit their offerings. Per review of staff training, there was documentation present of	R146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R146	Continued From page 15 staff training. However, there is no evidence of documented training regarding Resident specific approaches, and continued training or supervision of staff regarding dealing with difficult behaviors.	R146		
R178 SS=J	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff were qualified to provide safe care to Residents with Dementia, specifically affecting Resident #1. Findings include: Per phone interview with Med Tech #1 on 1/9/2021 at 11:49 AM, s/he has frequently been the recipient of Resident to staff physical aggression. S/he has not been provided with adequate training to appropriately care for Residents with difficult behaviors. The Med Tech reports that s/he did spend time with the House Manager during orientation, and has done the provided independent studies. However, s/he has had limited training and/or support in managing Residents with difficult behaviors. Per an interview with the House Manager on 2/3/2021 at 4:30 PM, s/he works with new hires	R178	It is understood that per R178, that enough staff shall be present to provide safe and consistent care to our residents. To that end, we have restructured our Orientation process so that orientees are not paired for duty until all orientation is completed. Training shall be provided in the classroom initially and subsequently in one of the facility buildings. Training is to be provided in the classroom by a Nurse and in the home by the Nurse and the House Manager. This process shall be completed and put into practice by June 1, 2021. ***What action you will take to correct the deficiency*** In addition to the above response regarding orientation, the nurse and Manager of the home will ensure staff is competent in all nursing care they are delegated to provide via direct observation of staff working with residents, prior to them working independently with residents without supervision. The competencies will be documented and retained in the home's records. Any new nursing care that staff is being delegated to provide will be assessed by the delegating nurse and training/competencies will be documented. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*** Each staff member shall be directly observed by the delegating nurse at least quarterly to ensure delegated nursing care is being rendered appropriately, including behavioral management. ***How the corrective actions will be monitored so the deficient practice does not recur*** The Manager and nurse will monitor the performance of nursing tasks by delegated staff via direct observation and review of resident records. If any needs around staff training are identified, any necessary education/training will be provided as soon as possible and documented.	June 1, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R178	Continued From page 16	R178		

during orientation. They spend 4 hours with her/him throughout the shift learning how to recognize behaviors and tricks to deal with them. S/he stated that s/he "used to be better at documenting specific training, but has not done so recently". S/he confirmed that there is no documented evidence of training that s/he has provided to staff regarding managing current specific difficult Resident behaviors.

On 2/10/2021 at 11:49 AM, during a phone interview, Med Tech #1 confirmed that s/he did not know what to do when Resident #1 became aggressive, and that s/he had not been aware of effective techniques to use when dealing with her/him. Per 'Facility to Nurse' note and written statement signed by a Med Tech and dated 11/28/2020, Resident #1 had become resistive to care and increasingly violent and combative towards the Med Tech, while being assisted with toileting. Another staff member attempted to intervene causing the Resident to become "more violent". On 1/25/21, the resident did not receive effective behavioral managment from the staff present at the time when similar behaviors were present, and Resident #1 became very agitated and aggressive, resulting in a fall with a head injury and passed away on 1/27/21. The House manager confirmed that if Med Tech #1 had used a different approach with Resident #1 on 11/28/2020 and 1/25/2021, the Resident would not have become combative.

Per phone interview with the facility Owner on 2/23/2021 at 11:45 AM, confirmation was made that there is no evidence that staff have received the annual 10 hours of additional classroom training specific to dementia care. S/he also confirmed that the minutes of staff meetings do not reflect actual time spent on dementia training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R178	Continued From page 17 See also R145 and R146.	R178		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to report an incident of Resident to Resident abuse to the Licensing Agency. Findings include: Per record review, Resident #2 was admitted to the facility from the hospital, after being transported there from a Residential Care Home (RCH) due to increased aggression and uncontrolled behaviors. As a result of these behaviors the RCH could no longer manage her/his care. The Resident had been restrained in the hospital for a period of time and administered Haldol (an antipsychotic medication used to treat acute psychosis), due to uncontrolled aggression. Per record review, Resident #2 has a pattern of assaultive behaviors. A facility Incident and	R208	It is understood that per R208, all resident to resident abuse incidents shall be reported to the state in an appropriate and timely manner. Resident care plans shall be updated by the Nurse when necessary to reflect changes in behavior patterns. The Nurse shall then educate care givers of said change(s). It is further understood, that Nurses shall be educated on how to write detail-oriented and client- specific notes for any call or written report to them. This education will be completed by May 1, 2021. Audits with documentation shall be conducted quarterly. ***What action you will take to correct the deficiency*** All resident to resident abuse, based on either allegations of abuse, an injury requiring physician intervention or a pattern of abusive behavior, will be reported to the licensing agency. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*** The Manager will review all incidents of resident to resident abuse to ensure reports are made when required by this regulation. ***How the corrective actions will be monitored so the deficient practice does not recur*** The Manager will monitor for compliance through the review of each incident.	May 1, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R208	Continued From page 18 Accident Report dated 1/22/2021 reflects that a Med Tech was attempting to get Resident #2 to sit down with her/his food and s/he grabbed the Med Tech by the arms and punched her/him in the throat. Per a facility Incident and Accident Report dated 1/24/2021 at 6:45 PM, Resident #2 was attempting to sit in a chair that was occupied by another resident. When a Med Tech attempted to stop her/him, the Resident started to punch the Med Tech. Per review of a facility Incident and Accident Report dated 2/5/2021 at 6:48 PM, Resident #2 had been getting physical with a staff member, walked away, and then walked up behind another Resident pushed [her/him] to the floor. During an interview with the facility Manager on 2/10/2021 at 6:15 PM s/he stated confirmed that the Resident to Resident incident that occurred on 2/5/2021 had not been reported to the licensing agency. Per interview with the facility owner on 2/10/2021 at 6:30 PM, s/he confirmed that the Resident to Resident incident had not been reported to the licensing agency because it did not require Doctor intervention, and it was not a pattern of abusive behavior. However, Resident #2 had a history of violent behaviors prior to admission, and 3 incidents of violent behavior toward staff prior to the Resident to Resident incident on 2/5/2021, this would represent a pattern of abusive behavior, requiring the facility to report it to the licensing agency.	R208		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with	R213		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R213	Continued From page 19 consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that one of four Residents in the applicable sample (Resident #1) was treated with dignity. Findings include: During an interview with the facility Owner on 2/3/2021 at 10:15 AM, when asked about a Med Tech that was involved in an incident that resulted in Resident #1 becoming aggressive toward staff, s/he stated that The Med Tech is "more apt to use words like 'shit' when talking to the residents". Per the Owner, the Med Tech has been counseled and educated on how to approach Residents. Per interview with the RN on 2/3/2021 at 10:30 AM, when asked about the Med Tech that had been involved in several incidents of Resident to staff aggression s/he stated "the only thing about [the Med Tech] is that [s/he] talks loud. [S/he] would tell a Resident 'Come on we are going to the bathroom'." The RN stated that "you get a more negative response because they don't want to do it". Per the RN, s/he is only involved in training staff for medication administration, not dementia care. The facility Owners and House Manager provide the mandatory and Dementia training. Per interview on with a Med Tech on 2/9/2021 at 12:30 PM, s/he recalled that on 1/25/2021 prior to Resident #1's fall, s/he was in the front of the house giving medications. S/he heard Med Tech	R213	It is understood that per R213, all residents shall be treated and cared for with dignity... In that light, education will be provided to all care givers by nurses regarding resident and family approach and communication. This education will be completed by June 1, 2021. ***What action you will take to correct the deficiency*** All staff will receive structured education on dignity and talking to, and about, residents in a respectful and dignified manner. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*** The Manager of the home will directly observe each staff member working with and talking about residents at least weekly, to ensure the dignity of all residents is maintained. If any re-education needs are identified, it will be provided immediately and documented. When the Manager has determined that there are no staff who talk to, or about, residents in a less than dignified way, the observations can be shifted to quarterly. ***How the corrective actions will be monitored so the deficient practice does not recur*** The Manager will ensure all staff receive training and will ensure observations of staff are completed weekly, then quarterly.	June 1, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R213	Continued From page 20 #1 down the hall say to Resident #1 "you need to take a shit on the toilet" and then "I told you if you if you need to take a shit you need to do it on the toilet". The Med Tech stated that "some of the things [s/he] says and how [s/he] says them, [her/his] mouth is the only problem I've seen". On 2/10/2021 at 6:30 PM during an interview, the Owner of the facility confirmed that saying things like "I told you if you if you need to take a shit, you need to do it on the toilet" to a Resident was not treating them with dignity or respect.	R213		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to provide a safe sanitary environment for the Residents in their care. Findings include: 1. Per review of a video recorded surveillance tape, on the evening of 1/25/2021 the two staff members on duty were observed throughout the video clip with no face coverings being worn. The two staff members were observed walking with Residents, assisting Residents, walking from the sitting room to the kitchen, walking and running up and down the hallway, speaking with the facility RN. The video shows the RN, who did	R266	It is understood that per R266, the home shall provide a safe and sanitary homelike environment. In that light, staff will be retrained as to the importance of wearing a face mask as well as hand-washing to uphold the safety of our residents and staff. This education will be provided by our Nurses and will be completed by April 1, 2021. Audits will be conducted and documented monthly x 6 months. ***What action you will take to correct the deficiency*** Training per the above facility response for all staff on all shifts. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*** Audits per the above facility response, also to utilize the security cameras so observers are observing staff on all shifts, but weekly until no breaches in infection control are observed, then monthly as stated above. ***How the corrective actions will be monitored so the deficient practice does not recur*** The Manager will ensure all staff are trained and weekly audits are continued for all shifts until no issues are observed, then monthly.	April 1, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R266	Continued From page 21 have a face covering on, having a conversation with both staff members without face coverings. There was no indication that the RN instructed them to put one on. At no time during the video did the two staff members wear a face covering. Per facility policy dated 6/12/2020, all staff must mask up before entering the facility. Per phone interview with the facility Owner on 2/23/2021 at 11:45 AM, wearing a face covering is a requirement unless staff indicate that their doctor says they can't because of underlying conditions such as asthma. "We can make it mandatory or let them go, I can't let them go. If they are doing resident care or are within 6 feet of the resident they have to wear a mask". When this Surveyor mentioned the facility video from 1/25/2021, where the staff members did not have face coverings on the Owner stated "I said that to [the detective] when we watched it [the video] together". Per facility Owner, there are 4 staff members that repeatedly state, their Doctor says they should not wear face coverings due to health conditions. These staff members have not received the COVID-19 vaccination, stating their Doctor has advised against it. According to the Centers for Disease Control (CDC), the facility should "implement source control for everyone entering a healthcare facility (e.g. healthcare personnel (HCP), patients, visitors), regardless of symptoms. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect HCP is unknown... As part of source control efforts, HCP should wear a facemask (Surgical or procedure masks) are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection to the wearer against exposure to	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	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
R266	Continued From page 22 splashes and sprays of infectious materials from others". A Memo released on 4/24/2020 by the Vermont Department of Health (VDH), states that "Health care personnel should wear a facemask at all times while they are in the facility". Reference: CDC, accessed 4/29/20: http://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html	R266		

196 Mussey Street
Rutland, Vermont 05701
802.773.4285

12/10/13 original date of re-creation requested from DAIL

4/1/21 Request for update to staffing patterns from DAIL

4/1/21 Request to alter SCU status

5/4/21 – Directed SCU plan elements (blue text) added by Division of Licensing and Protection

Department of Aging and Independent Living
Division of Licensing and Protection
Attn: Pamela Cota

As per your request and in a telephone conversation with Licensing Chief, Pam Cota, I am submitting this information for the file.

Re: Special Care Unit Status

Name:	Our House R.C.H. 162 Jackson Ave. Rutland, VT	Our House Too R.C.H. 69 ½ Allen St. Rutland, VT	Our House Outback R.C.H. 196 Mussey St. Rutland, VT
Special Care Units since:	**3/31/2003**	**3/23/2003**	**5/17/2010**

5.6.b A request for approval must include all of the following:
(1) A statement outlining the philosophy, purpose and scope of services to be provided;
(2) A definition of the categories of residents to be served;
(3) A description of the organizational structure of the unit consistent with the unit's philosophy, purpose and scope of services;
(4) A description and identification of the physical environment;
(5) The criteria for admission, continued stay and discharge; and
(6) A description of unit staffing, to include:
    i. Staff qualifications;
    ii. Orientation;
    iii. In-service education and specialized training; and
    iv. Medical management and credentialing as necessary.

(1)(2) – Our House was established on March 13, 2001 to care for people with dementia. Our philosophy has always been "less is more when it comes to medication", "laughter is the best medicine" and that the care that we deliver; the compassion, patience and perseverance will allow our residents, and their families a superior living experience. That people with dementia deserve a small homey environment that is conducive to their physical and cognitive

needs. That good care givers' become family. Our goal has always been to allow our residents to live at Our House through the end of life and that natural death is understood and accepted.

(1) Scope of services: The special care units will provide, upon a resident's admission to a Special Care Unit, necessary services to meet the residents' personal, psychosocial, nursing and medical care needs. Medication Administration: Due to the population that we serve, we find that medication administration is the safest, most secure manner of managing medications for our residents.

(2) Categories of residents to be served: The special care units will admit and care for residents with dementia or other forms of cognitive impairment that are appropriate for this setting and do not exceed the level of care for which the homes are licensed, unless a variance is obtained.

(3) Our House was established by Paula and Pasquale Patorti, as a result of our own personal experience. Paula and Pasquale are the proprietors – Each special care unit is structured as follows:

Paula – Administrator on call 24/7
Pasquale – Buildings and Grounds 24/7
Registered Nurse(s) on call 24/7
Senior Managers – AP, AR, PUR, HR
House Manager - on call 24/7
Med Certified Staff
Personal Care Givers

Our purpose is to allow people with dementia to live at Our House through the end of life, to make their living experience as positive and pleasant as possible. To comfort and calm them personally, to take care of their daily needs in a manner that they are comfortable with, at a time that they are most willing to accept such care and that when the time comes, natural death is understood and accepted. To maintain compliance with state and CMS regulations and to earn respect from our state licensing agency as we strongly believe that Our House is a good model for the future of community care, especially for people with dementia.

(4) Each house has a combination of single and double rooms:

OH	- 8 private rooms, 1 semi-private = 10 beds
OH Too	- 9 private rooms, 2 semi-private = 13 beds
OH OB	- 12 private rooms = 12 beds

Each house has a large common area, a parlor or small gathering room, a kitchen and dining room that are open to view though secured by half doors when necessary. Each house has three bathrooms, one being designated to staff and visitors. Each house is designed with a wandering loop. Each house has a secure, fenced in backyard that is open for the residents to enjoy. Each back door has a chime that announces to staff that someone is in the backyard. Each house has a keyless entry keypad to enter and exit the building that is state approved and connected to the fire alarm box. Each house has the necessary fire alarm and sprinkler system and is maintained and inspected at least annually or as required by regulation. Each house has a video surveillance system in common areas and on outside entry doors for security.

(5) The criteria for admissions are simply that the resident must have some kind of dementia as we believe it is unfair and uncomfortable to co-inhabit people who are cognitively impaired with those who are not. Continued stay would be determined on a case-by-case basis when the home would be required to request a level of care variance. ***In cases where families consider life sustaining influences such as a ventilator or respirator discharge would be immediate.***

(6)i. Description of unit staffing and staff qualifications: Each special care unit has a minimum of two (2) caregivers on duty at all times. Managers at each home will have completed specialized Dementia Care training prior to assuming the Manager position, or will be a licensed nurse. A Registered Nurse oversees the nursing care of all residents in each special care unit. Direct care staff members will have completed specialized Dementia Care training as outlined below prior to working independently with residents, and have annual and ongoing education as described below.

(6)ii. Orientation: Orientation includes the seven (7) mandatory training topics for all licensed Residential Care Homes as listed below, and in addition to those basic requirements, includes a total of at least 8-12 additional hours of classroom and clinical Dementia Care training prior to working independently with residents.

Mandatory topics for all Residential Care Homes:
(1) Resident rights;
(2) Fire safety and emergency evacuation;
(3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid;
(4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation;
(5) Respectful and effective interaction with residents;
(6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and
(7) General supervision and care of residents.

Nurse-led Dementia Care education has been added to our Orientation process which will be completed prior to any new staff beginning work with our residents. This training will be repeated at least annually and upon any identified training needs or new resident needs. Orientation process will include four (4) to six (6) hours of nurse-led clinical Dementia Care orientation for all employees, and an additional four (4) to six (6) hours of nurse-led Dementia Care training which will include:

i. A general overview of Alzheimer's disease and related dementia;
ii. Communication basics;
iii. Creating a therapeutic environment;
iv. Activity focused care;
v. Dealing with difficult behaviors; and
vi. Family issues.

Curriculum to be used: Alzheimer's & Dementia Training & Education Center

(6)iii. In-service education and specialized training:

See above regarding annual and ongoing Dementia Care training provided. Ongoing in-service training shall be provided to all nursing and non-nursing staff, including volunteers, who have any direct contact with residents of the unit. Staff training shall occur **at least quarterly**. So that all of our staff have the same knowledge, our Nurses shall be providing Dementia Care training to each care giver. At least annually, the Administrator shall query an audit of this education of which records shall be kept.

Mandatory ongoing in-service education will continue, with at least monthly presentations which will include RN involvement. The role and responsibility of the RN as written in the RCH Regulations for Nursing overview must be fully understood and will be reviewed with current and future RN's. The RN is responsible for training staff and delegating all nursing care.