



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

August 2, 2024

Shannon Blanchard, Manager
Our House Outback
196 Mussey Street
Rutland, VT 05701-4839

Dear Ms. Blanchard:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 7, 2024**. Please post this document in a prominent place in your facility.

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Carolyn Scott".

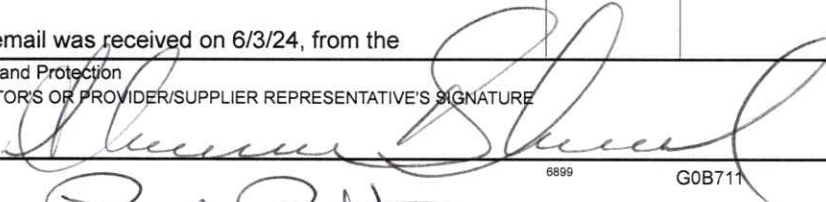

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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 complaint investigation of one complaint was conducted by the Division of Licensing and Protection on 6/03/24 to 6/7/24. Regulatory deficiencies identified during the investigation which resulted the need for Immediate Corrective Action to be taken by the facility. The facility did provide an Immediate Plan of Correction on 6/03/24. Findings include:	R100		
R134 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, Vermont Resident Assessment not completed for 2 out 4 residents (Resident #1, #4). Per record review Resident #1 moved into the RCH on 2/8/24 and Resident #4 moved in 2/13/24, the records did not contain completed initial Vermont Resident Assessments. Per interview on 6/3/24, at 2:00 PM, the Owner confirmed the records for Resident #1 and Resident #4 do not contain completed initial assessments completed. An email was received on 6/3/24, from the	R134	<i>This was an isolated incident - Previous RN oversight - RN and manager found and assessments were done to correct oversight prior to the surveyors arrival. Manager will monitor assessments on a monthly basis or in the event of a significant change to assure compliance.</i>	5/26/24 6/3/24

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Manager	(X6) DATE 7/26/24
STATE FORM  owner	6899 G0B711	If continuation sheet 1 of 10 7/31/24 8/1/24

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	--	--

NAME OF PROVIDER OR SUPPLIER
OUR HOUSE OUTBACK

STREET ADDRESS, CITY, STATE, ZIP CODE
**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
R134	Continued From page 1 Registered Nurse. The email contained the Vermont Assessments, however, the dates of completion exceeded 14 days after move in. Resident #1 assessment was completed on 5/26/24 and Resident #4 was completed on 5/26/24. The deficient practices are a potential for more than minimal harm, as assessments identify the care needs of Residents and assist the RCH in directing the staff of care to provide to residents.	R134	R134- Acceptable- 8-2-24-C.Scott LTCM	
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 observation, staff interview and record review the RCH failed to ensure sufficient number of qualified staff are available at all times to provide individualized care, a safe and supervised environment, or to assure prompt, appropriate action to address resident needs and other emergencies. This REQUIREMENT is NOT MET as evidenced by: Per observation through the course of the onsite visit, staff were observed to assist residents in transfers from sit to stand, and to and from chair and wheelchair. Staff provided assistance with	R178 R178	A few new staff have finished training and are on schedule *Each shift has 2 Caregivers.* Caregivers, managers, owners are filling voids, some staff are doing 12 hr - 16hr shifts, other shifts are broken up into 3 or 4 hours intervals. We continue interviewing potential staff to get more caregivers on board - This is a challenging time as the staffing crisis is effecting all industries - We do our best to fill staffing voids and will continue to do so - Resident #2 is no longer with us and Resident #1 has gained strength thru PT - we are still in need of staff and have not considered any new admissions since 2/24 to give our residents the attention they need. manager and owner will continue to monitor.	6/3/24

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 2</p> <p>one assist stand by, one-person physical assistance, and 2 staff person physical assist transfers. Staff were observed to walk along with residents utilizing ambulatory devices (i.e. Walkers), and providing physical assistance with locomotion, by pushing wheelchairs.</p> <p>Per record review conducted on 6/3/24 the facility was noted to have two residents assessed to need two-person assistance with care and activities of daily living (Resident #1 and Resident #2).</p> <p>1.) Resident #1 was admitted on 2/8/24 with diagnosis of dementia, chronic anemia, malnutrition, COPD, and chronic lower back pain. The Initial Vermont Assessment completed on 5/26/24 indicates Resident #2 care needs in sections G.1Physical Functioning: Activities of Daily Living; sub-section, 2a Transfers: Extensive Assistance, 2b. Two Plus persons Physical Assist, in sub-section 3a. Locomotion in Residence (Mobility): Extensive assistance, 3b.: Two Plus Physical Assist, and in section G3. Physical Functioning Modes of Locomotion: with primary mode of transportation of a wheelchair, other person wheeled, wheeled self.</p> <p>2.) Resident #2 was admitted on 4/13/18 in a annual Vermont Assessment completed on 4/1/24 identifies the level of care needs in sections G.1Physical Functioning: Activities of Daily Living; sub-section 1a. Mobility in Bed: Total Dependence, 1b. Two Person physical Assist, in sub-section 2a Transfers: Total Dependence, 2b. Two Plus persons Physical Assist, in sub-section 3a. Locomotion in Residence (Mobility): Total Dependence, 3b. Person Physical Assist.</p> <p>Per record review of the facility's Emergency</p>	R178	<p>STATEMENT: The written emergency evacuation plan is written as required by RCH regulation 9.11.c and is designed to assist Emergency personnel in the event of a necessary evacuation.</p>	
------	--	------	---	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 3</p> <p>Evacuation Plan updated on 4/19/24 states "In the event of a disaster, which necessitates evacuation of the facility, the following steps will be taken depending on the emergency it may be necessary to evacuate residents from the building. In this situation the following criteria must be considered and the manager of the facility or a duty designated staff member must make the final decision. If the situation is mild in nature and expected to be corrected within a few hours the residents can be transported to the managers emergency short term shelter at any of the other houses [there are four (4) "Our House" facilities in total] more residents may be split up and taken to other houses."</p> <p>Per record review of the facility's employee schedule conducted on the afternoon of 6/3/24 it was noted that on 5/11/24, 5/12/24, and 5/13/24, Staff #2 was scheduled alone and without assistance on third shift. Additionally, on 6/3/24 (the date of the onsite survey) it was noted that one staff member was scheduled for evening shift, 2:00 PM - 10:00 PM. This was confirmed by the Manager upon initial schedule review and confirmed again by the Human Resource Manager and Owner at approximately 10:30 AM. Per interview with the facility's Manager conducted on the morning of 6/3/24 s/he stated that Staff #2 has physical mobility limitations and is currently utilizing a walker to help ambulate around the facility. S/he stated that Staff #2 is unable to assist residents with standing, ambulation, or repositioning. S/he additionally added that the facility is often left with one staff member on duty.</p> <p>Per interview with the facility Owner conducted on the afternoon of 6/3/24 it was confirmed that there have been shifts at the facility with only one</p>	R178	R178- Acceptable- 8-2-24- C.Scott LTCM	
------	---	------	--	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 4</p> <p>staff member. When questioned how the facility is providing a safe and supervised environment, or is assuring prompt, appropriate action to address resident needs and other emergencies situations s/he stated that "employees are instructed to contact another facility for assistance." The Owner confirmed to have provided Staff #2 with a walker to use during his/her shift. The Owner confirmed not to have observed Staff #2 performance of job-related expectations to ensure competency and ability.</p> <p>Per interview with the facilities Human Resources Manager, s/he confirmed that the facility is occasionally staffed with one staff member stating "yes, we can't help it if people call out of work". When asked if staffing records for call out and schedule changes are on file, the HR Manager stated, "No we don't keep a record of call outs, and we have other licensed homes and work as a team. Staff can call other homes for help if they are alone." When asked if s/he believes Staff #2 could evacuate all the facility residents in the event of a fire per the facility evacuation plan s/he stated, they believed in the event of an emergency, adrenaline would allow Staff #2 the ability to evacuate.</p> <p>Per request of the facility's policy and procedures regarding staffing for residents needs, it was noted that the facility does not have a developed policy and procedure regarding adjuting staffing ratios in relation to fluctuations of the home's acuity of resident care needs.</p> <p>Per review of the licensing files for the home, and review of communication between the facility and the Division of Licensing and Protection, the home proposed a required plan/agreement to operate the Special Care Unit (SCU) on February</p>	R178		
------	---	------	--	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 5</p> <p>1, 2010 which is required by the Licensing Agency upon requesting to operate a SCU in Vermont. This plan outlines the agreement of how the facility will provide adequate staffing to provide for the needs of the residents within the SCU, specifically bullet point "6" of the plan stating, "There will be three shifts. There will be 12 hours per day when there are two caregivers on duty and 12 hours per day when there are three caregivers on duty.</p> <p>In response to a survey conducted on February 23, 2021, a request to update staffing patterns was submitted to the Division of Licensing and Protection for approval on April 1, 2021. On May 4, 2021, permission was granted from the Division of Licensing and Protection as follows: "Each special care unit has a minimum of two (2) caregivers on duty at all times." The facility has failed to provide adequate staffing per their request.</p> <p>In conclusion, this deficient practice results in Immediate Jeopardy as the facility staffing patterns fails to ensure consistent safe and adequate staffing based on residents assessed level of care and needs to provide individualized prompt care of all residents including in times of an emergency. The facility houses multiple residents who require at least one capable direct care provider to ambulate safely as well as at least two residents requiring at least two capable direct care staff to ambulate safely. Because of these residents' needs, the facility is required to maintain at least two capable and competent direct care staff on site at all times as recognized by the facility itself.</p>	R178		
------	---	------	--	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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 6	R213		
R213 SS=F	<p>VI. RESIDENTS' RIGHTS</p> <p>6.1 Every resident shall be treated with 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure care was provided in a safe setting by staff trained and oriented the home. Findings include:</p> <p>Per observation throughout the course of the onsite visits of the facility, the residents of the home require support throughout the day with activities of daily living, to include care staff support with memory impairment. Staff were observed redirecting wandering residents, preparing, and assisting with meals, and assisting residents with transfers and ambulation.</p> <p>Per interview on 6/3/24 at 8:40 AM, the Manager confirmed all the residents of the home have memory impairment and require an individualized approach for support and assistance throughout the day for activities daily living and individualized care approached in support of behaviors and cognitive impairment. The Manager confirmed staff have expressed concerns of negative verbal interactions they have witness by Staff #1. The Manager indicated Staff #1 has been observed to speak with inappropriate tones and language toward residents, and not utilizing individualized care interventions with residents. The Manager noted to have conversations with Staff #1 at</p>	R213 R213 R213	<p>mandatory scheduled in-service meetrnngs held on:</p> <p>6/12 - Staff care needs and problem Solving and on</p> <p>7/10 - Respectful and effective Communications, expectations For all Caregivers were the Focus. Respect, dignity, Individuality and privacy for our residents was discussed in depth at these trainings. Video trainings from Teepa Snow and Naomi Feil were viewed and discussed on these topics.</p> <p>All have been reminded to reach out immediately if they are Concerned about a Co-workers behaviors .</p> <p>Any Concerns will be followed up on immediately by a Manager, RN or an Owner.</p> <p>Concerns, meetrnngs or extra trainings will be written by the presenter (manager, RN or owner) and will include detailed Follow-up -</p>	7/10/24

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 7</p> <p>change of shift to "check-in" and provide support and guidance in communication. The Manager confirmed the Owner was made aware of staffs expressed concerns.</p> <p>Per interview on 6/3/24 at 10:45 AM the Owner confirmed to be aware of the concerns staff have expressed of Staff #1. The Owner indicated Staff #1 is "young" and "needs time." Staff #1 was hired in March of 2024.</p> <p>Per interview on 6/3/24 at 11:40 AM the Manager of Our House Too confirmed Staff #1 is scheduled at Our House Outback and Our House Too locations. The Manager is aware of reports concerning interactions Staff #1 with residents. The Manager of Our House Too stated Staff #1 requires coaching in behavior management techniques with residents and the use of appropriate body language.</p> <p>Per staff interview, on 6/3/24 at 12:05 PM, staff confirmed to have witnessed interactions Staff #1 has with residents. S/he explained Staff #1 uses tones that are loud, and language that does not demonstrate effective individualized communication. S/he explained the residents wander through the home and will enter rooms that are assigned to other residents, and Staff #1 will tell residents "to go somewhere" and "go sit", without providing redirection, addressing unmet needs, or provide individualized approach to care. Staff confirmed to have reported concerns to the Manager.</p> <p>Per staff interview on 6/5/24 at 12:30 PM, Staff confirmed to have witnessed Staff #1 speak to residents without a respectful tone. S/he explained the residents will ask about loved ones, who may have passed, Staff #1 will reply with</p>	R213	R213- Acceptable- 8-2-24- C.Scott LTCM	
------	---	------	--	--

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 8</p> <p>statements such as, "They are dead." in which then the resident becomes upset. S/he stated to have tried to support Staff #1, with guidance in appropriate ways to speak to residents with memory impairment. Staff confirmed to notify the manager of concerns of Staff #1 tone when speaking to residents.</p> <p>Per staff interview on 6/7/24 at 9:30 AM, s/he confirmed to have witnessed Staff #1 provoking Resident # 3. S/he explained, Resident # 3 experiences sundowning symptoms and will become anxious, in occurrences of Resident #3 experiencing anxious behaviors, Staff #1 will say "You're crazy." Staff confirmed to have reported concerns to the Manager/Owner. Staff stated "[Staff #1] will cause harm to someone and [Staff #1] should not be a caregiver." Staff confirmed Staff #1 has been left alone for shift within the facility, after having reported concerns related to the care and treatment of residents.</p> <p>On 6/3/24 2:00 PM the Human Resource (HR) Manager provided education trainings records of Staff #1 for review. The HR Manager also had Staff #1 present at the time the records were presented to surveyors. Staff #1 agreed to an interview.</p> <p>Per interview on 6/3/24 at 2:00 PM, Staff #1 confirmed to have assumed the caregiver role in March 2024. S/he explained to have previous experience as a Licensed Nursing Assistant and the license is currently inactive. S/he explained to have received about two weeks of on-shift-scheduled training provided by the Manager. S/he confirmed to have had conversation with the HR Manager and Owner, on the topic of performance and proper ways to speak with residents. Staff #1 stated, "There was</p>	R213		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/07/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OUR HOUSE OUTBACK	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 9</p> <p>that shift I was here alone, and [Owner] texted me to see how I was doing." Staff #1 was unable to confirm a date of conversation with the Owner.</p> <p>Per interview on 6/3/24 at 1:15 PM, the Owner confirmed no additional onsite observations, or evaluations of competencies were completed, and/or additional training assigned to Staff #1. The owner confirmed to have spoken with Staff #1 with expectation of performance and has texted Staff #1 during shifts to "check in". The Owner was unable to provide documentation to support additional support measures/ conversations provided to Staff #1, and confirmed there was no documentation to account for the concerns expressed by staff.</p> <p>This deficient practice is a potential for more than minimal harm as evidence of interview demonstrates the facility is failing to ensure all Facility residents have the right to be treated with consideration, respect and full recognition of the resident's dignity, by all Direct Care staff whom are to be trained and demonstrate competency within in their respective job related expectations.</p>	R213		
------	---	------	--	--