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 27, 2021

Ms. Paula Patorti, Manager
Our House Too Residential Care Home
196 Mussey Street
Rutland, VT 05701

Dear Ms. Patorti:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 21, 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
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
	0377	A. BUILDING: _____ B. WING	C 04/21/2021

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

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R100	Initial Comments: An unannounced on site investigation of three complaints and one facility reported incident was conducted by the Division of Licensing and Protection on 4/19/2021- 4/21/2021. 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		
R128	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to ensure that medications were administered per physician's orders for two of eight residents in the applicable sample (Resident #2 and Resident #8). Findings include: 1. Per record review, Resident #2's Medication Administration Record (MAR) for 8/1/2020 - 8/31/2020 reflects a physician's order for Risperidone (an atypical antipsychotic medication used to decrease behaviors) 0.25 mg PO (orally) BID (twice daily) PRN (as needed). The Per direction of an RN on 8/3/2020 the Risperidone was administered three times; once at 2:00 AM for "wandering into other resident's rooms", then at 7:00 PM for "agitation", and 9:00 PM for "agitation", exceeding the twice daily PRN	R128	RN's have been re-educated to the definition of PRN orders- If a PCP directs RN to use PRN meds "regularly" RN must obtain a detailed order. i.e. "temporary order" with detailed instructions. Further, when approving an OTC medication it must be used for the reason on the standing orders, any difference also requires a physicians order. RN's and Managers will monitor monthly or when med changes occur.	4/26/21

R128 - R224 POC accepted 5/26/21 SFreemanRN/PHL

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R128	Continued From page 1 physician prescribed order. Resident #2's 9/1/2020- 9/30/2020 MAR states Risperidone 0.25 mg PO 1 Tab BID PRN. The hour of administration documented in the MAR is 8:00 PM daily as a scheduled medication, not PRN. Staff initials document that the Risperidone ordered as PRN was actually administered at 8:00 PM on 9/1- 9/6 and 9/7- 9/30/2020. The Residential Care Home Licensing Regulations state "'PRN medication' means medication ordered by the physician that is not to be administered routinely but is prescribed to be taken only as needed and as indicated by the resident's condition." During interview with the RN on 4/19/2021 at 12:00 PM she/he confirmed that Resident #2's Risperidone 0.25 mg was ordered as needed, and staff were instructed to administer it at 8:00 PM daily. 2. Per facility standing orders signed by the physician on 7/28/2020, Resident #2 has a PRN order for Benadryl (an antihistamine) 25 mg every 6 hours for itching/congestion. Documentation in the resident's MAR reflects that on 8/3/2020 at 2:00 AM, per direction of the RN on call, the Med Tech administered Benadryl 25 mg for wandering. During interview with the house RN on 4/20/2021 at 4:15 PM, the RN confirmed that the Benadryl was not administered as physician ordered, stating that it is "sometimes used to help them sleep a little". 3. Per record review Resident #8's MAR dated 12/1/2019 through 12/31/2019, reflects a physician's order for Seroquel (an antipsychotic)	R128		

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R128	Continued From page 2 12.5 mg PO BID PRN. The documentation in the MAR indicates that the resident received Seroquel 12.5 mg at 8:00 AM and 8:00 PM everyday on 12/1/2019 through 12/16/2019. The MAR also reflects physician's orders for Diazepam 2 mg PO Noon PRN for anxiety. Staff initials documented in the MAR reflect that the PRN Diazepam was scheduled for 12:00 PM on 12/1, 12/3, 12/4, 12/6 through 12/13/2019. Documentation in the MAR states that on 12/14/2019 the resident "Refused 12 PM meds says makes [her/him] tired", and on 12/15/2019 resident #8 "refused 12 PM 2 mg Diazepam says [she/he] doesn't want to sleep". Per interview with the RN on 4/19/2021 at 12:00 PM when the RN contacts the physician regarding resident behaviors and requests an order for a scheduled dose of a medication, the RN is asked if staff are utilizing the medication that is ordered as needed for behaviors. If the PRN medications are not being used, the physician will not order a scheduled dose. The RN confirmed that she/he directed staff to administer the PRN medications as a consistent scheduled medication.	R128		
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.	R136		

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R136	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the Registered Nurse (RN) failed to update the Resident Assessment (RA) when there was a change in condition for one of eight residents in the applicable sample (Resident #1). Findings include: Per record review, Resident #1 was admitted on 5/22/2019. An admission assessment completed by the RN on 6/3/2019 documents the resident was able to self-propel in their wheelchair, ambulated and wandered with an unsteady gait. On 8/6/2019 Resident #1 began receiving Hospice services. There was no change in condition assessment completed at that time. An annual assessment dated 5/6/2020 documents that resident #1 self-propels in WC, is totally dependent on others for mobility while in bed, is a two person transfer, and totally dependant on staff for all activities of daily living (dressing, grooming, eating, toileting, bathing). A Hospice clinical note dated 1/25/2021 documents the need for repositioning every two hours, wound care for pressure ulcer on coccyx, and maximum assistance with a Hoyer lift for transfers into a high back wheelchair. Per nurses and Hospice notes, the resident has had a significant decline in mobility, behavior, mentation. This documentation reflects a significant change in condition warranting a resident assessment to be completed by an RN. There is no evidence in the residents record that a change in condition assessment was completed. During observations on 4/21/2021 at approximately 10:00 AM, Resident #1 was observed being transferred from a chair to	R136	Each resident shall be assessed annually and whenever changes occur. 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. 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. We will track when annual resident assessments are due, and the RN will complete assessments prior to or on the due date. RN's and Managers will meet weekly to assess needs and discuss residents status for compliance.	5/15/21 6/15/21

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R136	Continued From page 4 wheelchair by two staff members with extensive assistance. She/he was observed throughout the investigation in bed, up in wheel chair, and in a recliner unable to reposition or transfer self. Per interview with a Med Tech on 4/20/2021 at 2:00 PM, Resident #1 is unable to self-propel in wheel chair, and needs total assistance with care and mobility. The Med Tech stated that Resident #1 has been on Hospice for over a year. During an interview on 4/20/2021 at 12:30 PM, the RN confirmed that a change in condition assessment had not been completed to reflect the changes in Resident #1's condition.	R136	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.	6/15/21
R145 SS=E	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; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the Registered Nurse (RN) failed to update the Resident Care Plan with updates or changes in condition, for four of eight residents in the applicable sample (Residents #1, #2, #6, and #7). Findings include:	R145	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 designed with positive effect the goal for 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.	4/26/21 ongoing

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R145	Continued From page 5 1. Per record review Resident #1's care plan dated 5/6/2020, documents that she/he is at risk for wandering, preventative care for skin integrity, and falls, she/he also self propels in her/his wheelchair into others. Interventions include; frequent position changes, preventative skin care, lap belt, and alarm. A Hospice clinical note dated 1/25/2021 documents the need for repositioning every two hours, wound care for pressure ulcer on coccyx, and maximum assistance with a Hoyer lift for transfers into a high back wheelchair. There is no evidence that the current care plan was updated to reflect the resident's changes in condition. During observations on 4/19/2021 at 10:00 AM, Resident #1 was observed in bed on his/her right side with a position alarm in place. During observation of the resident's room, there was a Hoyer lift, and notes on the wall near the head of the bed reflecting the resident's care needs. The resident's wheelchair was noted to have a lap belt attached. On 4/20/2021, at approximately 9:45 AM, two staff members were observed transferring Resident #1 from a recliner to a wheelchair. During interview on 4/19/2021 at 2:00 PM, with a Med Tech, she/he stated that updates are posted on the walls in the resident's room and on the refrigerator in the facility kitchen. The Med Tech also stated that at times there are individual update sheets placed in the Care Plan Binder. She/he confirmed that resident #1's current care plan does not reflect the resident's changes in condition and interventions. 2. Per record review Resident #2's admission assessment dated 7/30/2020 lists behaviors of wandering, verbally abusive, physically abusive,	R145	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. 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 will shift to quarterly.	6/1/21 6/15/21

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R145	Continued From page 6	R145		

socially inappropriate, and resists care daily, all documented as not present or easily altered. The resident care plan dated 7/30/2020 documents behavior as alert, noisy, uncooperative, irritable, and confused. The documented plan is "redirect with behaviors". Resident #2's Behavior Plan dated 7/30/2020 identifies behaviors as attractive to females and resists care. The documented plan includes "attempt to redirect from female residents (signs do not enter on doors), redirect with TV shows-westerns, golf, likes sweets, and call RN for PRN". There is no documented plan or interventions in the care plan or behavior plan that address preventing or managing wandering, verbal abuse, or physically abusive behaviors.

3. Per record review, on 10/1/2019 the house manager held a care plan conference with resident #6's family. Per care plan conference notes, the family was informed that Resident #6 had developed a friendship/relationship that with another resident. Care plan conference notes do not address any interventions implemented. The care plan signed as updated on 2/1/2020, and 1/29/21 were not updated to reflect the need for monitoring or any needed interventions regarding the relationship with the other resident.

Per interview with Med Tech on 4/19/2021 at 2:00 PM he/she confirmed that resident #6's care plan did not reflect the relationship or any updated interventions related.

4. Per record review, on 10/1/2019 the house manager held a care plan conference with resident #7 and her/his family. Per care plan conference notes, the family was informed of a friendship/relationship that resident #7 had developed with another resident. During this conference the house manager documented that

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R145	Continued From page 7 resident #7 was to be monitored and family to be informed with concerns. Resident #7's care plan dated 9/30/2019 was not updated to reflect the need for monitoring or any interventions regarding the relationship. Per interview with Med Tech on 4/19/2021 at 2:00 PM he/she confirmed that Resident #7's care plan did not reflect the relationship, or the need to monitor the resident. During interview with RN on 4/20/2021 at 3:30 PM, she/he confirmed that she/he does not update individual care plans at the time of changes. The RN stated that the standard care plan located in the binder and the updates are done separately and posted in kitchen or in residents' rooms.	R145	RN's have been reminded to the definition of PRN medications, If a pcp directs an RN to use PRN meds regularly an order must be obtained in detail to reflect pcp's detailed intentions. RN's and Managers will monitor monthly or when med changes occur. RN's have reviewed and updated all written behavior plans and have reviewed with med techs to assure they are all accurately documenting the reasons and effects of all PRN medications administered. RN's will routinely ask what interventions have been done based on the written behavior plan and when the PRN was last administered prior to approval of any anti-psychotic medication and to assure that physicians orders are followed. RN will monitor MAR for completion and accuracy.	5/21/21
R155 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on interview and record review the RN failed to ensure that resident medications were administered and documented according to the home's policies. Findings include: 1. The facility policy related to PRN psychoactive medication administration state "staff who meet the criteria to administer PRN medications may	R155		

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R155	Continued From page 8 administer PRN psychoactive medication only when a written plan for the use of the medication has been developed and addresses the following: 1. A description or statement of specific behaviors that the medication will address or correct. 2. A description of the circumstances, which indicate the use of the medication. 3. Staff is knowledgeable about the desired effects and side effects of the medications. 4. The location of documentation that indicates the time the medication was administered: the reason for the medication and the effects of the medication each time the medication is administered." Per record review Resident #2 has physician's orders for Lorazepam 0.5 mg every 2 hours PRN anxiety. Resident #2's behavior plan implemented on 7/30/2020 does not document the use of Lorazepam and does not address what behaviors the medication will address or correct, the circumstances for use, desired effects, or side effects of the medication. Per review of Resident #2's MAR, she/he received Lorazepam 0.5 mg on 9/15/2020 and 9/21/2020 for restlessness, on 9/23/2020 for "antsy agitated", on 9/28/2020 and 9/29/2020 for restless behavior. Per review of the resident's MAR, she/he also has physicians orders for Risperidone 0.25 mg PO 1 Tab BID PRN. Her/his behaviors include "attracted to females" and "resists care". Per documentation on the resident's MAR she/he received the PRN Risperidone 0.25 mg on 8/2/2020 for "acting out", on 8/3/2020 for "wandering into other resident's rooms", on 8/3/2020 at 7:00 PM and 9:00 PM for agitation, and 8/31/2020 for agitation. None of the documented behaviors are addressed on the	R155		

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R155	Continued From page 9 behavior plan. Per Resident #2's behavior plan staff is to attempt to redirect from female residents (sign do not enter on doors) redirect with TV shows-westerns, golf. Likes sweets, Call RN for PRN" There is no description of the circumstances indicating the use of the medication addressed in the behavior plan. Per interview with the facility RN on 4/20/2021 12:00 PM Med Techs are expected to call the on call nurse prior to administering a PRN medication and the RN determines when a medication should be administered. 2. The facility Documentation of Medications policy states documentation will include at a minimum, the following "All PRN medications administered, including the date, time, reason for the medication and the effect". On 8/2/2020 a Med Tech administered the PRN Risperidone for "acting out "there is no documentation of the effect the medication had on the resident. On 8/31/2020 a Med Tech administered Risperidone 0.25 mg per nurse for agitation. There is no documentation reflected in the MAR of the time it was administered or the effect. Documentation on the resident's MAR indicates that staff administered the PRN Risperidone 0.25 mg at 8:00 PM, on 9/1, 9/2, 9/3, 9/7, 9/8, 9/15, 9/16, 9/17, 9/21, 9/22, 9/24, and 9/28, with no reason or effect documented. Per MAR, staff administered Lorazepam on 8/17/2020 with no effect of the medication documented. On 9/15/2020, the Resident #2 received Lorazepam PRN for restlessness with no time administered or effect documented. On 9/21 and 9/28/2020 Lorazepam was administered	R155		

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R155	Continued From page 10 with no time or effect documented. On 9/29/2020 Lorazepam was administered for restless behavior with no effect documented. During an interview with the RN on 4/20/2020 at 12:00 PM she/he confirmed that staff should be documenting times administered, and the effects of PRN medications on residents.	R155		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to ensure that an applicant who was hired by the	R181	When we agree to offer someone with a background an opportunity to work at Our House, they must present a written explanation of what happened, and what they have done since then to correct their behavior. In addition to other state expectations as outlined in a memo effective 7/1/15. We monitor performance and do not tolerate any unbecoming behavior. This individual hasn't worked for us since February of 2020 when she stopped showing up to work. We consider a no-show grounds for immediate dismissal.	ongoing

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R181	Continued From page 11 facility did not have a conviction of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to public welfare. Per review of an employees personal file a criminal record check was obtained by the facility on 8/19/2019. The results of the background check revealed that the employee had criminal convictions including; false pretenses or false tokens on 11/17/2011, stolen property on 4/3/2013, disorderly conduct- fight etc. on 4/16/2018, and unlawful trespass on 3/27/2019. Per review of the employee's education file, the facility began orientating the employee on 8/20/2019. During interview with a House Manager on 4/28/2021 at 12:04 she/he stated that the staff member worked at all of the facilities, however she/he was no longer an employee of the facility.	R181		
R194 SS=J	V. RESIDENT CARE AND HOME SERVICES 5.14 Restraints 5.14.a Mechanical restraints may be used only in an emergency to prevent injury to a resident or others and shall not be used as an on-going form of treatment. The use of a mechanical restraint shall constitute nursing care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the Registered Nurse (RN) failed to ensure that a mechanical restraint was used for an emergency only, and was not an ongoing	R194	Lap belt was removed, the belt was intended for safety not a restraint. Physician and family have been updated. Resident will be monitored closely to make sure when seated in a wheelchair that she is safe from sliding down/out of the chair. Staff have been updated to the lap belt being discontinued and that the resident must be in bed or in a recliner when caregivers cannot be with her. Lap belts will not be used in anyway unless deemed necessary by the PCP and only when all facets of regulations can be met and are approved by the licensing agency. Care plan has been updated. Manager and RN will monitor for compliance.	5/10/21

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R194	Continued From page 12	R194		

treatment for one of eight residents, (Resident #1) in the applicable sample. This noncompliance poses an immediate risk of serious harm to this resident. Findings include:

Per record review, Resident #1 was admitted to the facility on 5/22/2019. On 6/10/2019 the house manager obtained a physician's telephone order for a "pelvic positioner" (lap belt). There is no evidence in the record that the use of the pelvic positioner was implemented as an emergency intervention to prevent injury to Resident #1. The use of the pelvic positioner has been used as an ongoing form of treatment since 6/11/2019.

The facility Risk Acknowledgement that families sign on admission states: "by law, your loved one is guaranteed the right to freedom of movement. That means we do not restrain residents with belts, ties, or devices that prevent rising".
The facility policy titled Restraints states "It is the intent of the facility to avoid any types of restraints, either chemical or mechanical at all times".

Per an Accident Injury Report Form on 7/7/2020 at 8:00 AM Resident #1 was unsupervised and had an unwitnessed fall while staff were providing care to other residents. The resident was found tipped over and strapped to her/his wheelchair with self releasing belt. The facility Restraint policy states that a resident restrained MUST be under constant supervision. There are no exceptions.

Per interview with the House Manager on 4/19/2021 at 1:48 PM, she/he is unsure when the lap belt was ordered. The house manager confirmed that the lap belt is applied daily while the resident is in the wheelchair.

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R194	Continued From page 13 Per interview with a Med Tech on 4/19/2021 at 2:00 PM she/he stated the lap belt is applied while the resident is in the wheelchair. The Med Tech states the resident has had the lap belt since he/she has worked at the facility. Per interview with the RN on 4/19/2021 at 3:30 PM the lap belt is applied when the resident is seated in the wheelchair. The resident has a history of sliding down in the wheelchair, and the lap belt helps to keep her/him in the chair. The RN confirmed that the restraint has been ordered for an extended period of time.	R194		
R195 SS=J	V. RESIDENT CARE AND HOME SERVICES 5.14 Restraints 5.14.b When a temporary mechanical restraint is applied by the staff, a physician must be consulted immediately and written approval for continuation of the restraint obtained. The written order, signed by the physician, should contain the resident's name, date, time of order, and reason for restraint, means of restriction, and period of time the resident is to be restrained. A record shall be kept of every time the restraint is applied and removed during the day and night. Restraints must be removed at least every two (2) hours when in use so as to permit personal care to be given. A resident in a restraint shall be under continuous supervision by the staff of the home. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the Registered Nurse (RN) failed to obtain	R195	Lap belt was removed, the belt was intended for safety not restraint. Physician and family have been updated. Resident will be monitored closely to make sure when seated in a wheelchair that she is safe from sliding down/out of the chair. Staff have been updated to the lap belt being discontinued and that the resident must be in bed or in a recliner when caregivers cannot be with her. Lap belts will not be used in anyway unless deemed necessary by the PCP and only when all facets of regulations can be met and are approved by the licensing agency. Care plan has been updated. Manager and RN will monitor for compliance.	5/10/21

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R195	Continued From page 14	R195		

a physician's order that contains the reason for the restraint and the period of time that the resident is to be restrained. The RN also failed to implement continuous supervision when the restraint is in use, and a record of when the restraint is applied and removed. This noncompliance poses an immediate risk of serious harm to this resident.

Per record review Resident #1 has a Physicians order for a pelvic positioner dated 6/11/2019. A Resident Assessment and Care Plan dated 5/6/2020 reflects restraint to be used daily while resident is in wheelchair.

Per an Accident Injury Report Form on 7/7/2020 at 8:00 AM Resident #1 was unsupervised and had an unwitnessed fall while staff were providing care to other residents. The resident was found tipped over and strapped to her/his wheelchair with self releasing belt. The facility Restraint policy states that a resident restrained MUST be under constant supervision. There are no exceptions.

Per interview with the House Manager on 4/19/2021 at 1:50 PM he/she confirmed that Resident #1 has had the restraint for an extended period of time, and it is applied daily while she/he in the wheelchair.

Per interview with Med Tech on 4/19/2021 2:00 PM he/she confirmed that the restraint is applied while out of bed in wheelchair. She/he also confirmed that the resident has had the restraint since he/she has worked at the facility.

Per interview on 4/19/2021 at 3:30 PM, the RN confirmed that the restraint is used while the resident is out of bed in wheelchair, and there is

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R195	Continued From page 15 no log for application or removal of restraint. The RN also confirmed that staff had not received education on use of the resident's restraint.	R195		
R197 SS=J	V. RESIDENT CARE AND HOME SERVICES 5.14 Restraints 5.14.d The home shall notify the licensing agency and the resident representative within 24 hours when a restraint is used, and within 72 hours must complete a reassessment of the resident to determine if the resident's needs can be met within the residential care setting. The reassessment shall include consultation with the physician and the resident or the resident's representative. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the Registered Nurse (RN) failed to notify the licensing agency when a restraint was implemented, and failed to reassess the resident with consultation with the physician. This noncompliance poses an immediate risk of serious harm to this resident. 1. Per record review of Resident #1's Resident Assessment completed by the RN, dated 5/6/2020, the section titled category of special treatments, documentation reflects that a trunk restraint as being "used daily". Review of care plan for resident #1 dated 5/6/2020 reflects under mobility device/fall risk, lap belt as preventative measure. There is no evidence in the record that the facility notified the licensing agency when the restraint was implemented. There is also no	R197	Lap belt was removed. Physician and family have been updated. Resident will be monitored closely to make sure when seated in a wheelchair that she is safe from sliding down/out of the chair. Staff have been updated to the lap belt being discontinued and that the resident must be in bed or in a recliner when caregivers cannot be with her. Lap belts will not be used in anyway unless deemed necessary by the PCP and only when all facets of regulations can be met and are approved by the licensing agency. Care plan has been updated. Manager and RN will monitor for compliance.	5/10/21

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R197	Continued From page 16	R197		

evidence in the record that the RN completed an assessment in consultation with the physician to determine if the resident's needs could no longer be met by the facility.

Per observation on 2/19/2021 and 2/20/2021 the lap belt restraint was in place while Resident # 1 was seated in a high back wheelchair. Lap belt was observed to be secured to resident's own wheelchair while resident is in bed.

Per an Accident Injury Report Form on 7/7/2020 at 8:00 AM Resident #1 was unsupervised and had an unwitnessed fall while staff were providing care to other residents. The resident was found tipped over and strapped to her/his wheelchair with self releasing belt. The facility Restraint policy states that a resident restrained MUST be under constant supervision. There are no exceptions.

Per interview with House Manager on 4/19/2021 at 1:50 PM she/he confirmed resident has had restraint since arrival to facility and uses the restraint daily while out of bed in wheelchair. Confirmed that staff apply it each time resident is out of bed.

Per interview with Med Tech on 4/19/2021 at 2:00 PM he/she confirmed that the restraint is used while the resident is out of bed in wheelchair for meals. She/he stated that the resident has had the restraint as long as he/she has worked here at the facility.

During interview with the RN on 4/19/2021 at 3:30 PM, she/he stated that the restraint was implemented because the resident would slide herself down in the wheelchair and the lap belt helped to keep her/him in the chair. She/he

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R197	Continued From page 17 confirmed that the restraint is used while the resident is out of bed in wheelchair for meals, no longer than an hour after.	R197		
R198 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.14 Restraints 5.14.e Residents shall have a right to be free from chemical restraints and unnecessary mechanical restraints. Residents shall be notified at the time a restraint is applied of their right to challenge the use of the restraint. A resident has the right to meet with and discuss the challenge with the following individuals: (1) The home manager; (2) The licensing agency; (3) The Commissioner of the licensing agency. In the event that a resident does challenge the use of a restraint, the home operator shall inform the licensing agency at the time the challenge is raised. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review the facility failed to ensure that two of eight residents in the applicable sample (Resident #2 and #8) were free from chemical restraints, or were provided the opportunity to refuse or challenge the use of a chemical restraint. Findings include: 1. Per record review, on 8/17/2020 at 2:45 AM, Resident #2 refused a PRN dose of Lorazepam 0.5 mg by mouth four times. Per documentation in the resident's MAR, with direction from the RN, the Med Tech then applied the Lorazepam	R198	Lap belt was removed. Physician and family have been updated. Resident will be monitored closely to make sure when seated in a wheelchair that she is safe from sliding down/out of the chair. Staff have been updated to the lap belt being discontinued and that the resident must be in bed or in a recliner when caregivers cannot be with her. Lap belts will not be used in anyway unless deemed necessary by the PCP and only when all facets of regulations can be met and are approved by the licensing agency. Care plan has been updated. Manager and RN will monitor for compliance. RN's have been re-educated to the definition of PRN orders- If a PCP directs RN to use PRN meds "regularly" RN must obtain a detailed order. i.e. "temporary order" with detailed instructions. Further, when approving an OTC medication it must be used for the reason on the standing orders, any difference also requires a physicians order.	5/10/21 5/15/21

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R198	Continued From page 18 topically, trying to alter the resident's behavior, eliminating the resident's ability to refuse the medication. Per Nurses Note on 8/17/2020 at 2:00 AM the Med Tech phoned the nurse, requesting permission to administer "a PRN" as Resident #2 was very agitated and they had been unable to redirect her/him. The nurse instructed the Med Tech to give Ativan 0.5mg orally and if unable, apply 0.1ml of topical Ativan. The nurse was not aware that just prior to this request, the resident was assaulting the staff and staff was abusing the resident (Med Tech had elbowed the Resident, and grabbed him/her in the genitals causing her/him to lower her/himself to the floor). 2. Per record review Resident # 8 has a history of agitation and anxiety with a Physician's order for Seroquel 12.5 mg PO BID PRN for "anxiety". Per record review Resident #8's MAR dated 12/1/2019 through 12/31/2019, reflects a physician's order for Seroquel (an antipsychotic) 12.5 mg PO BID PRN. The documentation in the MAR indicates that the resident received Seroquel 12.5 mg at 8:00 AM and 8:00 PM every day on 12/1/2019 through 12/16/2019. The MAR also reflects physician's orders for Diazepam 2 mg PO Noon PRN for "anxiety". Staff initials documented in the MAR reflect that the PRN Diazepam was scheduled for 12:00 PM on 12/1, 12/3, 12/4, 12/6 through 12/13/2019. Documentation in the MAR states that on 12/14/2019 the resident "Refused 12 PM meds says makes [her/him] tired", and on 12/15/2019 resident #8 "refused 12 PM 2 mg Diazepam says [she/he] doesn't want to sleep". Per interview with the RN on 4/19/2021 at 12:00 PM, the RN confirmed that she/he directed staff	R198	RN's will ask med tech when the last dose was administered and if all interventions have been attempted and what results were (if any) before giving permission for any prn med to be administered. RN's and Managers will monitor monthly or when med changes occur.	5/15/21

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R198	Continued From page 19 to administer the PRN medications as a consistent scheduled medication. "Chemical Restraints" is defined as any drug that is used for discipline or convenience and not required to treat medical symptoms. "Discipline" is defined as any action taken by the facility for the purpose of punishing or penalizing residents. "Convenience" is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. See also R224.	R198		
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure that two of eight Residents in the applicable sample (Residents #2 and #3) were free from physical abuse. The facility also failed to ensure that three of eight Residents in the sample (Residents #1, #2, and #8) were free from chemical or mechanical restraints. Findings include:	R224	RN's have been re-educated to the definition of PRN orders- If a PCP directs RN to use PRN meds "regularly" RN must obtain a detailed order. i.e. "temporary order" with detailed instructions. Further, when approving an OTC medication it must be used for the reason on the standing orders, any difference also requires a physicians order. Med techs have been given detailed instructions from the RN's. RN's and Managers will monitor monthly or when med changes occur. RN's will ask med tech when the last dose was administered and if all interventions have been attempted and what results were (if any) before giving permission for any prn med to be administered. RN's and Managers will monitor monthly or when med changes occur.	5/15/21

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R224	Continued From page 20 1. Per record review, Resident #2 has a history of aggressive behaviors and resisting care. On 8/17/2020 at 1:45 AM Resident #2 was involved in staff to Resident abuse with a Med Tech in which the Resident sustained skin tears to her/his wrist. The Med Tech also grabbed Resident #2's genitals, causing her/him to lower her/himself to the floor. A facility Accident Incident Injury Report completed by the Med Tech on 8/17/2020 states the Resident was "getting into the cabinets taking binders out ADL books ect. [The Med Tech] took them away to prevent him from taking all the papers out. [The Med Tech] put them back in the cupboard and blocked [her/him] from taking them out." The Med Tech describes the altercation as "[the Resident] hit me upside the head and neck, grabbed me around my neck struggled to get her/his arm free around my neck, tuned around quickly and went to see the other aide". The Med Tech reported that she/he assisted the other aide with another Resident, prior to Resident #2 being assisted. The other aide went to check on the Resident "as [she/he] was sitting on the floor." The Resident was found by the other aide on the floor, with two skin tears on her/his right wrist. The Med Tech did not document hitting the Resident, or grabbing her/his genitals to get away from her/him. Per reviewed video footage of the incident (does not contain audio), Resident #2 was sitting at the kitchen counter with binders in her/his hands. After a verbal exchange, the Med Tech attempted to pull the binder from the Resident's hands. When the Resident resisted, the Med Tech struck her/him on her/his hands and wrists several times before the Resident let go of the binders and the Med Tech gaining possession of them. The Med Tech continued to engage in a verbal exchange	R224	All caregivers are aware of the importance of their role as mandated reporters. We continue to discuss this at every monthly in-service, during the interview process and during orientation training. Enhanced training program will reinforce the expectations and responsibility of mandated reporters. Caregivers will sign a memorandum of understanding as to their role as a mandated reporter and the expectations of proper/timely reporting. RN and Manager will monitor for compliance.	6/15/21

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R224	Continued From page 21	R224		

over the counter top, and the Resident reached acrossed the counter and struck the Med Tech in the face. The Med Tech walked away with the binders and returned on the side of the counter that the Resident was seated to put the binders in a cupboard. She/he placed the binders in the cupboard next to the resident and walked away. The Resident attempted to take the binders out again, and the Med Tech returned and stood between the Resident and the cabinet where the binders were located, preventing her/him from obtaining them. After another verbal exchange, the Resident struck the Med Tech in the head several times. During this altercation the Med Tech elbowed Resident #2 in the neck and pushed her/him away from her/him. The Resident wrapped her/his arm around the Med Tech's neck. The Med Tech reached back, grabbed her/him in the genitals, and then removed the Resident's arm from around his/her neck. Resident #2's legs wobbled and she/he slowly lowered her/himself to the floor. The Med Tech walked away leaving the Resident on the floor, unattended, bleeding from two skin tears she/he had sustained during the altercation.

Per statement provided by the other staff member on duty, earlier in the shift, the Med Tech involved in the altercation had threatened to "deck" the Resident if she/he didn't leave the kitchen. However, the aide did not intervene or notify the nurse, manager, or owner of the threat made to the Resident. After the altercation, the Med Tech also reported to her/his coworker that she/he had grabbed the Resident by the 'balls' during a physical altercation with her/him and the aide still did not interviene or notify anyone.

Per statement provided by the Med Tech, she/he had been "trying to hit the counter as opposed to

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R224	Continued From page 22 the client's arm to get her/him to let go of the binder." She/he also stated that she/he had been frustrated due to being called derogatory and offensive names. Per interview with the facility owner on 4/20/2021 at approximately 5:30 PM, the aide that was on duty when the incident occured assisted the Resident, and reported the incident later to a cowrker. The coworker then made managment aware of the incident, and the video was reviewed. The Med Tech was questioned and terminated from employment. 2. Per record review, on 8/17/2020 at 1:45 AM, Resident #2 was involved in staff to resident abuse when a Med Tech failed to utilize appropriate person centered behavior techniques with a Resident with Dementia. Per Nurses Note on 8/17/2020 at 2:00 AM the Med Tech phoned the nurse, requesting permission to administer "a PRN as [Resident #2] was very agitated and they had been unable to redirect her/him. [The Med Tech] reported that [the Resident] refused to stay in bed and was up going through closets. [The Med Tech] said [she/he] was trying to redirect [the Resident] so [she/he] wouldn't get hurt and [she/he] then turned on [the Med Tech] and choked [her/him], after [the Resident] hit [her/him] in the head. [She he] tried to get away from [the Resident] and somehow [the Resident] incurred 2 skin tears on her/his wrist. Instructed [the Med Tech] to Ativan 0.5mg orally and if unable apply 0.1ml of topical Ativan." The nurse was not aware that the Med Tech had elbowed the Resident, or grabbed him/her in the genitals causing her/him so lower her/himself to the floor. Per facility standing orders signed by the physician on 7/28/2020, Resident #2 has a PRN	R224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0377	A. BUILDING _____ B. WING _____	C 04/21/2021

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

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R224	Continued From page 23 order for Benadryl (an antihistamine) 25 mg every 6 hours for itching/congestion. Documentation in the resident's MAR reflects that on 8/3/2020 at 2:00 AM, per direction of the RN on call, the Med Tech administered Benadryl 25 mg for wandering. During interview with the house RN on 4/20/2021 at 4:15 PM, the RN confirmed that the Benadryl was not administered as physician ordered, stating that it is "sometimes used to help them sleep a little". Per interview on 4/19/2021 at 12:00 PM the RN stated that when staff call to report falls, injuries of unknown origin, Resident to Resident, or Resident to staff altercations she/he asks questions like "did they have shoes on, things like that." The RN confirmed that other than staff completing the Accident Incident Injury Report, there was no formal process to investigate the specific cause of incidents. The RN stated that recently a section has been added to the Accident Incident Injury Report to request review of the video surveillance if there are questions. However, based on the report made to the RN by the Med Tech involved in the incident, and the fact that the other aide did not report the Med Tech, the Med Tech was allowed to continue the shift, provide care to the Resident, and administer medications for increased agitation. The Med Tech who was found to have abused Resident #2, administered a medication as a chemical restriant to control behaviors that were origanilly caused by ineffective behavior interventions. 3. Per record review, on 11/2/2020 at approximately 6:14 PM Resident # 3 was attempting to sit in a chair in the living room. Another resident who is known to display aggression to others who sit in that specific chair	R224		

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R224	Continued From page 24 approached Resident # 3 and pushed him/her to the floor, causing Resident #3 to sustain a fractured hip. Per review of video servalance of the incident, Resident #3 was ambulating toward a chair when the Resident with known possesive behaviors stood from the chair she/he was sitting in, approached Residnet #3 who was standing in front of the other chair, and pushed her/him to the floor. There were no staff present in the room at the time of the incident, however they did respond after the incident. Per interview with the manager of the facility on 4/20/2020 at 11:00 AM, both staff members on duty were in the kitchen area and could not see the residents who were in the living room. The manager stated that she/he heard Resident #3 fall and responded right away, finding her/him on the floor. The manager stated that the other resident is territorial and considers the chair her/his. Staff try to keep the chair empty, and when staff see someone going toward it they redirect them. The manager confirmed that there is not always someone in the room supervising the residents to ensure no one sits in the chair. 4. Per record review, Resident #1 was admitted to the facility on 5/22/2019. On 6/10/2019 the house manager obtained a physician's telephone order for a "pelvic positioner" (a belt that is attached to the wheelchair and fastened around the waist of the Resident to prevent slidding from the chair). The resident is unable to remove the belt. The facility Restraint policy states "It is the intent of the facility to avoid any types of restraints, either chemical or mechanical at all times" and "in the event of a resident whose safety or safety of other residents or staff	R224	When a resident displays any kind of aggressive behavior it is to be documented on the care plan and a written behavior plan should be developed with appropriate interventions intended for positive results, all will be reviewed with caregivers by the RN and Manager. Events resulting in a physicians intervention or if a pattern evolves the licensing agency will be informed as per regulation as in this case APS was also informed. Lap belt was removed, the belt was intended for safety not a restraint. Physician and family have been updated. Resident will be monitored closely to make sure when seated in a wheelchair that she is safe from sliding down/out of the chair. Staff have been updated to the lap belt being discontinued and that the resident must be in bed or in a recliner when caregivers cannot be with her. Lap belts will not be used in anyway unless deemed necessary by the PCP and only when all facets of regulations can be met and are approved by the licensing agency. Care plan has been updated. Manager and RN will monitor for compliance.	ongoing 5/10/21

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R224	Continued From page 25 members is at risk; a restraint may be used. There is no evidence in the medical record that suggests that Resident #1's safety required the intervention of a mechanical restraint. Per interview with the RN on 4/19/2021 at 3:30 PM the restraint was utilized because the resident "would slide down in the chair, and it helped to keep her/him up in the chair." 5. Per record review Resident # 8 has a history of agitation and anxiety with a Physician's order for Seroquel 12.5 mg PO BID PRN for anxiety. Per record review Resident #8's MAR dated 12/1/2019 through 12/31/2019, reflects a physician's order for Seroquel (an antipsychotic) 12.5 mg PO BID PRN. The documentation in the MAR indicates that the resident received Seroquel 12.5 mg at 8:00 AM and 8:00 PM everyday on 12/1/2019 through 12/16/2019. The MAR also reflects physician's orders for Diazepam 2 mg PO Noon PRN for anxiety. Staff initials documented in the MAR reflect that the PRN Diazepam was scheduled for 12:00 PM on 12/1, 12/3, 12/4, 12/6 through 12/13/2019. Documentation in the MAR states that on 12/14/2019 the resident "Refused 12 PM meds says makes [her/him] tired", and on 12/15/2019 resident #8 "refused 12 PM 2 mg Diazepam says [she/he] doesn't want to sleep". Per interview with the RN on 4/19/2021 at 12:00 PM, the RN confirmed that she/he directed staff to administer the PRN medications as a consistent scheduled medication.	R224		