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

December 6, 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 **September 22, 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
	0377	A. BUILDING: _____ B. WING _____	C 09/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site compliant investigation was completed by the Division of Licensing and Protection on 9/22/2021. There were regulatory violations identified during this investigation.	R100	The filing of this plan of Correction does not constitute an admission of the allegations set forth in the Statement of deficiencies. This plan of Correction is prepared and executed as evidence of the facilities continued Compliance with applicable law/regulations.	
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to report an allegation of abuse to the licensing agency or Adult Protective Services as required. Findings include: Per record review Resident #1 was admitted on 3/11/15 with diagnoses of schizophrenia, stroke, and dementia. A behavior plan dated 3/1/2021 states that Resident #1 has increased anxiety-seeking attention all the time especially when other residents are being tended to, and has increased aggression -yelling, screaming, swearing. The plan includes intervention of redirection, remove from stimulation, explain that swearing is not appropriate, toileting, bring outside, and s/he loves music and to sing.	R207	A required mandatory assignment of all Caregivers has been Completed including watching the DPS Video on the DAIL website (47 min) and demonstrated understanding in a written exercise. For proof of understanding to be repeated for new hires and monthly x 3 — Based on the facts and Chain of events the Finding reflect inconsistency: monitoring of required training will be done by the HR manager — Any and all reports of N, N-E will be reported as has always been our intention. Caregivers, managers, RN's and Administrator will monitor for Compliance monthly or as needed.	11/22/21 2/22/22

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

Owner — 12/3/21 — ~~11/01/21~~

R207 - R213 POC accepted 12/6/21 PMcotarn

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R207	Continued From page 1 During an interview on 9/22/2021 at 10:13 AM the facility owner stated that a resident assistant (RA #1) had informed her/him that another RA (RA#2) had told RA #1 that s/he had concerns regarding how the facility manager was treating residents. According to the owner RA #1 also stated that RA #2 had told her/him that s/he had called the state regarding how the facility manager talks to Resident #1. Per the owner, s/he had approached the manager after RA #1 reported this and asked if s/he "had ever crossed the line" with Resident #1 and the manager said no s/he hadn't. The owner confirmed that s/he had not reported RA #2's concerns/allegations to the licensing agency. S/he stated that s/he did not report it because she did not feel it was true and was "just a rumor." Per interview with RA #1 on 9/22/2021 at 11:59 AM s/he stated that RA #2 had told her/him that the manager tells Resident #1 that s/he "is a whinny little bitch." RA #1 confirmed that s/he had told the owner about RA #2's allegation. However, the owner did not report it to the licensing agency as required by regulation.	R207	"You can provide anyone an opportunity, but you can't make them take it"	
R213 SS=D	VI. RESIDENTS' RIGHTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review the facility failed to	R213		

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R213	Continued From page 2 ensure that staff treated one of three residents in the sample (Resident #1) with consideration, respect and dignity. Findings include: Per record review Resident #1 was admitted on 3/11/15 with diagnoses of schizophrenia, stroke, and dementia. S/he has limited verbal communication, typically speaking one to three words. S/he does communicate and make her/his needs known. A behavior plan dated 3/1/2021 states that Resident #1 has increased anxiety-seeking attention all the time especially when other residents are being tended to, and increased aggression -yelling, screaming, swearing. The plan includes intervention of redirection, remove from stimulation, explain that swearing is not appropriate, toileting, bring outside, and she loves music and to sing. During an interview on 9/22/2021 at 10:13 AM the facility owner stated that a resident assistant (RA #1) had informed her/him that another RA (RA#2) had told RA #1 that s/he had concerns regarding how the facility manager was treating residents. According to the owner, Resident #1 uses foul language when s/he is having a" temper tantrum" and the manager will say "We don't talk like that here" and "bribe [her/him] with cookies". Per interview with RA #1 on 9/22/2021 at 11:59 AM s\he stated that RA #2 told her/him that the manager tells Resident #1 that s/he "is a whinny little bitch". RA #1 reported to the owner so s/he would know. During observations throughout the day of 9/22/2021 Resident #1 was observed out of bed self propelling her/himself in a wheelchair. While this surveyor was speaking with the owner s/he asked Resident #1 if s/he "loved [the manager]"	R213	Resident Rights are posted in the house – A mandatory assignment for all Caregivers has been Completed including locating, reading and Completeing a demonstrated written exercise as proof of understanding those rights. This exercise will be repeated x 3 months and for all new hires. 11/22/21 All Caregivers know they are expected to monitor residents at all times to ensure they are being treated with dignity and respect – any concerns are to be reported at once. 2/22/22 Caregivers, managers, RN's and administrator will monitor daily for Compliance	

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R213	Continued From page 3 and s/he replied "yes". The owner also asked her/him if the manager "gave her cookies" and s/he replied "yes". The owner then replied "yeah, you love [the manager], don't you?" Resident #1 answered "yeah". This exchange does not respect the dignity of the resident. During interview on 9/22/2021 at 12:15 PM Resident #1 was smiling and appeared relaxed. S/he had propelled her/himself into their room for privacy to speak with this surveyor after the exchage with the owner witnessed by the surveyor. This interview was also witnessed by an investigator from the Attorney General's office. When asked "Are staff good to you here?" Resident #1 paused and stated, "a little bit." I then asked, "Does anyone here ever treat you badly? S/he responded "Sometimes." When asked "has anyone here ever hurt you?" her/his face began to turn red, and s/he began to cry. I again asked if anyone had ever hurt her/him. S/he stated "Yes." This surveyor asked her/him if it was certain people who hurt her or if it was everyone there, s/he stated "No". The question was rephrased, "Is it everyone?" S/he stated "No". I then asked if it was just one person and s/he replied "Yes". I asked questions regarding gender and was able to confirm whether it was a female/male. When asked if it was [the manager] s/he stated "Yes" and began to cry harder. I asked her/him if the named person had ever hurt her/his body and s/he stated "No." When asked if s/he has hurt her/his by using words s/he stated "Yes". Resident #1 was asked if s/he could tell me what words were used that hurt her/his feelings s/he did not respond. Between each question the resident was given time to formulate more in-depth replies. S/he would try to express in more detail what s/he wanted to communicate but could not. S/he continued to cry throughout the	R213		

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