VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 12, 2025

Shana Lee, Manager
Our House Residential Care Home
196 Mussey Street
Rutland, VT 05701-4551

Dear Ms. Lee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 20, 2025.** Please post this document in a prominent place in your facility.

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

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

Sincerely,

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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0360	A. BUILDING: _____ B. WING _____	C 10/20/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments On 10/20/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident and one related complaint. The following deficiencies were identified:	R100	Corrective actions for all deficiencies cited accepted by Jo A Evans RN on 11/12/25. Please refer to the attached document to review the corrective actions for all deficiencies cited.	
R159 SS=D	5.9.c (2) Nursing Services For each resident requiring a nursing overview, administration of medication, or nursing care, the registered nurse must: Develop a person-centered written plan of care within 14 days after admission, in accordance with the nursing process and professional standards of practice, for each resident that is based on abilities and needs as identified in the resident assessment. The resident, and if the resident chooses, resident representatives such as family or close supports, must be invited and allowed to participate in care planning meetings. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being, and must be revised as the resident?s abilities and needs change This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure one applicable resident's Care Plan describes care and services necessary for the Resident's well-being; and identifies goals and interventions to address the changes in Resident's abilities and needs (Resident #1). Findings include:	R159		

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R159	Continued From page 1 The home's policies and procedures related to Resident Care Plans are consistent with this licensing rule. Per record review, Resident #1's diagnoses include severe memory impairment and multiple medical conditions including a recent diagnosis of severe osteoporosis. On 10/1/25 Resident #1 sustained a fall with injuries while residing at another home, Our House Outback, managed and owned by the same organization. Nursing oversight is provided by the same RN to both Our House Outback and Our House Residential Care Home. Resident #1 was transported to the Emergency Room where they were diagnosed with a right hip fracture, COVID-19 infection, and a urinary tract infection. Resident #1 was hospitalized for inpatient care including surgical repair to stabilize their hip fracture and treatment of infections. Resident #1 was discharged back to their former residence, Our House Outback, on 10/13/25 with identified needs including strict fall precautions and continuation of Physical and Occupational therapy services provided during hospitalization. Hours after discharge from the hospital, Resident #1 returned to the Emergency Department due to shoulder pain and inability to lift their right arm. Resident #1 was subsequently diagnosed with a right upper arm fracture, which is an injury of unknown origin. Following assessment and treatment in the Emergency Department on 10/13/25, Resident #1 returned to their previous home. At approximately 10:35 AM on 10/20/25, the Registered Nurse responsible for nursing oversight including development of resident care plans confirmed Resident #1 continued to test positive for COVID-19 on 10/14/25 and further	R159		

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R159	Continued From page 2 testing had not been conducted since this date. At 12:45 PM on 10/20/25, the Receiver confirmed Resident #1's home health Physical Therapist performed an initial assessment and provided instructions for Resident's needs to the Owner of the home and the Registered Nurse on 10/15/25. At 10:52 AM on 10/20/25 the Manager confirmed Resident #1 was transferred to this home on 10/17/25. Per record review, the care plan on file for Resident #1 had not been updated since the Resident's admission to the home on 4/1/25 and had did not identify and address the Resident's current needs related to falls with injuries, transfers and mobility, risk for post-operative infection, COVID-19 infection with prolonged positive test results; and needs related to diagnoses including severe Dementia, osteoporosis with significant demineralization of bone structure, acute on chronic anemia, and Vitamin B-12 deficiency which all pose a risk to Resident #1's well-being. At 2:47 PM on 10/20/25 the Receiver provided a copy of a template they created to address their observation of the home's Care Plans as incomplete, and confirmed Resident #1's care plan does not identify and address Resident #1's current needs.	R159		
R161 SS=J	5.9.c (4) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Provide instruction and oversight to all direct care personnel regarding each resident's health care	R161		

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R161	Continued From page 3 needs and nutritional needs. Delegate nursing tasks as appropriate, following the Board of Nursing?s recommended practices, with adequate documentation of delegation; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review there is a failure to ensure adequate provision of instruction and oversight to all direct care staff by the Registered Nurse responsible for nursing oversight of the home to ensure one applicable Resident's health care needs are met (Resident #1). Findings include: Per the Manager's confirmation at 10:52 AM on 10/20/25, and per record review, on 10/17/25 Resident #1 was transferred to Our House Residential Care Home from Our House Outback both which are managed by the same organization following a series of accidents, injuries, and changes in condition. Per record review, on 10/1/25 Resident #1 sustained a fall with injuries and was transported to the Emergency Room where they were diagnosed with a right hip fracture, COVID-19 infection, and a urinary tract infection. Resident #1 was hospitalized for care including surgical stabilization their hip fracture and treatment of infections, then discharged back to their former residence on 10/13/25. Hours after returning home, Resident #1 returned to the Emergency Department due to shoulder pain and inability to lift their right arm. Resident #1 was subsequently diagnosed with a fracture of their right upper arm, which is an injury of unknown origin. Per record review Resident #1 returned to their previous home without re-admission to the hospital. At 12:45 PM on 10/20/25, the Receiver confirmed	R161		

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R161	Continued From page 4 Resident #1's home health Physical Therapist performed an initial assessment of Resident #1 and provided instructions for Resident's care to the Owner and the Registered Nurse on 10/15/25. 1. Per observation. at approximately 10:15 on 10/20/25, two staff on duty at the home were observed lifting Resident #1 from their chair and ambulating the Resident to the bathroom as the Resident was heard repeatedly saying "ow" and expressing pain. Due to the Surveyor's position in the room during this incident, it initially appeared the Staff on duty ambulated Resident #1 without the assistance of a gait belt; however the Receiver provided video surveillance footage of this incident which showed the Staff lifting and ambulating Resident #1 with a gait belt that had been left on Resident #1 during a previous encounter. As the Staff ambulated Resident to the bathroom, the Resident's gait appeared to be unsteady with the assistance of 2 staff, and the Resident appeared to be having difficulty safely managing this activity. Staff were also observed ambulating Resident #1 during the afternoon on 10/20/25. Per record review, Resident #1's plan of care does not include documentation of a plan for safe and effective transfers, mobility and toileting; and Resident #1's Progress Notes do not document the instructions received from the hospital or home health agency regarding staff assistance with these activities of daily living. Per review of Physical Therapy notes obtained from the applicable home health agency as they were not maintained on file in resident #1's record, Resident #1's Physical Therapist's initial assessment notes on 10/15/25 include multiple references to use of a wheelchair. Per record	R161		

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R161	Continued From page 5 review, the Physical Therapy notes state Resident #1 is non-ambulatory pending their "right shoulder orthopedic appointment", and indicate Resident #1 requires stand-pivot transfers with the assistance of 2 staff from bed to wheelchair to toilet while awaiting this appointment. At 1:05 PM on 10/20/25 the Registered Nurse confirmed the Orthopedic appointment referenced in the Physical Therapist's note was scheduled for 10/23/25. Per observation, a wheelchair was not in use for Resident #1 on 10/20/25, and Resident #1's Progress Notes do not document a follow up conversation with the Orthopedic Physician or the Physical Therapist to clarify if Resident #1 is able to ambulate without the use of a wheelchair. 2. The Physical Therapist's notes also identify Resident #1's need to elevate their legs above the level of their heart to manage edema, and indicate wheelchair foot rests are needed to assist Resident #1 with elevating their feet. At 11:32 PM on 10/20/25 the home health provider on site for a home visit confirmed Resident #1's Physical Therapist documented orders for the home to ensure hydration, rest, and elevation of legs above heart. Resident #1 was observed seated in the living room and resting in bed without their legs elevated throughout the investigation conducted on 10/20/25. When the Surveyor approached the Registered Nurse about the order to elevate Resident #1's legs at 3:50 PM on 10/20/25 the Registered Nurse responded "I know". At 4:55 PM on 10/20/25 the Receiver confirmed this order was not followed. 3. Per observation, on the morning of 10/20/25 Resident #1 verbally expressed pain while being ambulated by Staff by saying "ow" repeatedly. Per record review, Resident #1's Physical Therapy	R161		

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R161	Continued From page 6 notes state during a pain assessment on 10/15/25 Resident #1 indicated pain in their right hip and right shoulder; however, due to severe dementia Resident #1 was unable to communicate the severity of their pain. Per review of Resident #1's hospital Medication Discharge Report dated 10/13/20, a signed physician's order was provided on discharge for Oxycodone 2.5 mg every 6 hours as needed for moderate to severe pain limited to a duration of no longer than 10 days and for use after first trying non-opioid therapy including over the counter medications and lidocaine patch. Per record review, this medication order was not entered on Resident #1's October 2025 Medication Administration Record, and documentation of a follow up conversation with Resident #1's physician regarding this medication order is not included in Resident #1's Progress Notes. Resident #1's Care Plan does not include a pain management plan. Per review of Resident #1's October Medication Administration Record, Resident #1 was administered PRN (as needed) over the counter analgesic medications 18 times over a 7 day time period between 2:20 PM on 10/13/25 and 1:30 PM on 10/20/25; however, the effects of administration were not documented by the Staff 50% of the time. These findings indicate Resident #1 is at risk for ineffective management of pain resulting from their hip and upper arm fractures. 4. The Registered Nurse's failure to ensure Resident #1's Care Plan is updated to provide written instructions regarding Resident #1's care needs; oversee coordination of Resident #1's care through communication with providers: document changes in Resident #1's condition and needs in Resident #1's Progress Notes; and oversee implementation of prescribed care	R161		

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R161	Continued From page 7 including the Physical Therapist's treatment orders and Hospital Provider's orders was determined by the Survey Team to be an immediate jeopardy to Resident #1's health and safety. The Receiver was informed of this determination of immediate jeopardy to Resident #1's health and safety at approximately 5:20 PM on 10/20/25. In response, the Receiver submitted a plan of immediate corrective actions to address this immediate jeopardy, which was reviewed and accepted by the State Long Term Care Manager at 6:16 PM on 10/20/25.	R161		
R170 SS=F	5.9.c (13) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Ensure that direct care staff follow current professional standards of practice and current infection control standards during provision of services; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the Registered Nurse failed to ensure the home's Direct Care Staff follow current professional standards of practice and infection control standards related to the transfer of a COVID positive resident (Resident #1) to the home from another Residential Care Home owned by the same organization. Findings include: Per record review, on 10/20/25 the infection control policies related to COVID-19 on file at the home were copies of the current standards	R170		

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R170	Continued From page 8 provided by the licensing agency and current Vermont Department of Health guidance. At approximately 3:00 PM on 10/20/25 the recently appointed Receiver confirmed they were in the process of revising the home's policies and procedures and developing comprehensive policies and procedures manual. 1. There is a failure to implement the use of masks by Staff in accordance with current professional standards of practice and current infection control standards identified by the Vermont Department of Health and the Division of Licensing and Protection. Per record review, Staff including Care Providers and the Registered Nurse responsible for nursing oversight of the home float between the Residential Care Homes owned by the same organization. Per record review conducted on 10/20/25, the Owners of the organization that manages the home notified all caregivers employed by the organization on 10/6/25 that staff and residents at 2 of the organization's homes had tested positive for COVID-19 infection. This notification stated "we need to take pre-cautions [sic]", and instructed staff to "wear a mask". Records reviewed on 10/20/25 indicated an in-service staff training occurred on 10/15/25 which included COVID-19 and Infection Control training; and indicated the home was in receipt of an email from the Assistant Director of the Division of Licensing and Protections sent on 10/15/25 regarding current acceptable infection control standards of practice to ensure resident care in a safe environment. Per record review, a reminder was also issued the home's Owners on 10/18/25 stating masks were required for staff until 10/24/25 unless additional positive COVID test results were received, which would extend	R170		

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R170	Continued From page 9 this date. On arrival at the home at approximately 10:00 AM on 10/20/25, a sign was observed on the exterior door indicating the home was a COVID positive environment. Upon entrance, a Staff who was not wearing a mask stated there were no COVID-19 positive Residents in the home. The Staff responded to the sign on the door by stating it was just a precaution that should have been taken down. When asked to verify the date the last positive case was diagnosed at the home, the Staff re-entered the home, returned wearing a mask, and re-stated there were no COVID-19 cases in the home. Per review, video surveillance footage inside the home recorded at 10:02 AM shows the Registered Nurse and a second Staff on duty without masks in the common area of the home. Additional examples of the failure to implement masking as an infection control measure include: a. A box of KN95 masks was observed to be accessible to all who enter the home on a table in the entryway foyer on the morning of 10/20/25. At 10:50 AM on 10/20/25, the Manager of the home was observed entering the home and walking into the Dining Room without a mask. When the Registered Nurse stated "you have to wear a mask" the Manager replied they were aware of this requirement and was observed putting on a mask. b. During an interview commencing at 1:36 PM on 10/20/25 the Staff stated they were not informed prior to or on arrival at the home on 10/20/25 that a Resident transferred to the home had tested positive for COVID-19, and confirmed they had not received instructions indicating	R170		

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R170	Continued From page 10 masks were required. c. Video surveillance footage provided for review on 10/20/25 shows unmasked Staff in the dining room with a resident present at 1:29 AM on 10/20/25; and a Staff improperly wearing a mask across their chin at 4:57 AM on 10/20/25. d. At 4:28 PM on 10/20/25 the Receiver confirmed they observed Staff working in the home without masks on 10/18/25 and 10/19/25 when they performed weekend check-ins at the home. 2. There is a failure to demonstrate competency in current infection control standards in response to Resident #1's positive COVID-19 test result on 10/14/25 and upon the transfer of multiple Residents from a COVID positive environment to the home. Per interview, when the Registered Nurse presented at the entrance of the home the Registered Nurse stated there were no COVID-19 positive residents at the home. On further questioning, the Registered Nurse confirmed Resident #1, who initially tested positive for COVID-19 on 10/1/25, continued to test positive for COVID-19 on 10/14/25 when surveillance testing was performed prior to the transfer of residents including Resident #1 to the home from Our House Outback. The Registered Nurse confirmed subsequent testing had not been performed since 10/14/25 to determine if Resident #1 or any other Residents of the home were COVID-19 positive. At 10:53 AM on 10/20/25 the Manager confirmed the transfer of Residents to the home occurred on 10/17/25.	R170		

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R170	Continued From page 11 Per review, Resident #1's record does not include documentation of monitoring for signs and symptoms of COVID-19, and documentation of a plan for monitoring all residents of the home for signs and symptoms of infection was not on file at the home. Per review of the guidance provided by the Assistant Director of Division of Licensing on 10/15/25, "Testing staff who were in close contact to a positive case remains an effective strategy for reducing further transmission." At approximately 3:55 PM on 10/20/25 the Registered Nurse reported surveillance testing had just been conducted at the home and all results were negative for COVID-19 infection. On the afternoon of 10/20/25, the Receiver confirmed surveillance testing conducted by the organization that manages the home including the testing conducted on the afternoon of 10/20/25 does not include staff testing. 3. The Registered Nurse's failure to ensure the home's direct care staff follow current professional standards of practice and current infection control standards was determined to be an immediate jeopardy to the health and safety of all residents of this home. This finding is evidenced by the Registered Nurse's failure to demonstrate and implement the use of masks as an infection control measure; ensure residents of the home are monitored for signs and symptoms of COVID-19; and implement a system to reduce the risk of resident exposure to COVID-19 by monitoring staff for symptoms, include staff in surveillance testing conducted at the home, and establish guidelines for staff return to work following a positive COVID test result.	R170		

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R210	Continued From page 12	R210		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. The training must include, but is not limited to, the following: (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; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced	R210		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE 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
R210	Continued From page 13 by: Based on staff interview and record review there is a failure to ensure one applicable staff completed all required training. Findings include: On 10/20/25 the recently appointed Receiver for the home was in the process of revising the home's policies and procedures and developing a comprehensive policies and procedures manual. As of 10/20/25, a policy identifying the trainings required by the licensing agency and procedures for staff completion of all required trainings had not been developed. On 10/20/25 the Manager of the home was requested to provide documentation of trainings completed by 5 sampled staff. Per review of the documentation provided for review, 1 out of 5 sampled staff did not complete the required trainings. This finding was confirmed by the home's court appointed Receiver at 4:39 PM on 10/20/25	R210		
R999 SS=F	Miscellaneous This REQUIREMENT is not met as evidenced by: 4.13.c The manager must not leave the premises without delegating necessary authority to a competent staff person who is at least eighteen (18) years of age. Staff left in charge must be qualified by experience to carry out the day to day responsibilities of the manager, including being sufficiently familiar with the needs of the residents to ensure that their care and personal needs are met in a safe environment. Staff left in charge must be fully authorized to take necessary action to meet those needs or must be able to contact	R999		

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R999	Continued From page 14 the manager immediately if necessary. This licensing rule is NOT MET as evidenced by: Per Staff interview, on the morning of 10/20/25 the Staff on duty including 2 Care Providers and the Registered Nurse responsible for nursing oversight of the home were unable to identify the individual the individual in charge of the home in the absence of the Manager and the recently appointed Receiver who were not present in the home. At 10:26 AM on 10/20/25 the Staff on duty were asked to identify the individual in charge of the home, and the Registered Nurse responded their was no one person who was appointed to be in charge. When the Staff were then asked which individual on duty was designated to carry out the responsibilities of the Manager, the Registered Nurse responded both Care Providers on duty were in charge with the Nurse's guidance if necessary. Per Surveyor observation and Staff interview, all staff on duty were unable to identify an individual delegated to perform the responsibilities of the Manager in the absence of the Manager and Receiver on the morning of 10/20/25. This finding was acknowledged by the Receiver on the afternoon of 10/20/25 during an update regarding the Surveyor's findings prior to the Receiver's arrival.	R999		

Deficiency Statement Plan of Correction (POC)

Survey Date: 10/20/2025

Facility Name: Our House

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R159	Resident #1 Care plan was updated	All residents have the potential to be impacted	11/14/2025	New care plan policy and format was developed and care plans for current residents were rewritten to identify goals and interventions to address changes in resident abilities and needs.	Receiver will audit resident care plans weekly X 4 and monthly X 3 and report findings to QA committee
R159 Plan of Correction accepted by Jo A Evans RN on 11/12/25				Consultant to provide education to RN's who provide oversight on care plan development and updates.	
R161	Resident #1 care plan was updated to reflect current needs relating to pain, mobility and recent injuries	All residents have the potential to be impacted	11/14/2025	To prevent future occurrences, the delegating RN will receive education regarding assessment and care planning, thoroughly reviewing all practitioner and hospital notes after a hospitalization or change in condition.. A second review will be completed by the Receiver to ensure all necessary care needs are addressed.	The receiver will complete weekly audits x4, and monthly audits X3 and report findings to QA committee.
				An Audit tracking form was created to ensure the center receives all documentation	

R161 Plan of Correction accepted by Jo A Evans RN on 11/12/25				after hospitalizations, physician visits and therapy appoingments	
F170	Resident # 1 tested negative for Covid on 10/20/2025	All residents of the center tested negative for covid on 10/20/25	10/29/25	Staff education was provided regarding current Covid protocols including masking.	Receiver will monitor compliance
			10/25/25	Daily unannounced center visits were made to document compliance with masking protocols	
	There have been no further positive cases of Covid.		11/1/25	Covid policy was updated to include staff testing as part of surveillance testing and staff return to work guidelines.	
			10/20/25	Receiver to manage future Covid outbreaks with guidance from the Vermont Department of Health.	
R170 Plan of Correcton accepted by Jo A Evans RN on 11/12/25			11/14/25	Rn and manager attended education of current Covid standards and protocols	
R210 R210 Plan of Correction accepted by Jo A Evans RN on 11/12/25	The staff member was a travel caregiver and is no longer assigned to the center.	Current staff education files were audited to ensure staff receive required trainings.	11/20/25	Policy for staff training was updated.	Receiver to review files of newly hired staff or travelers to ensure required training is completed.
R999 R999 Plan of Correction accepted by Jo A Evans RN on 11/12/25	No residents were adversely impacted.		10/29/25 and 11/14/25	A new policy for delegating authority in the absence of the facility manager was created. Staff education was provided on 11/14/25	