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

December 8, 2025

Helen Bishop, Manager
Our House Too Residential Care Home
196 Mussey Street
Rutland, VT 05701

Dear Ms. Bishop:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 17, 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
	0377	A. BUILDING: _____ B. WING _____	C 11/17/2025

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 On 11/17/25 the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey and investigations of one complaint and one facility reported incident. Deficiencies related to the annual survey and the complaint investigation were not identified. The following deficiencies were identified related to the facility reported incident:	R100		
R232 SS=D	5.12.c (5) Records/Reports Any reports, allegations, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property must be reported to the licensing agency. i. The licensee and staff must report any case of suspected abuse, neglect or exploitation of a resident to Adult Protective Services (APS). A separate report must also be made to the licensing agency. APS may be contacted by calling toll-free 1-800-564-1612. The licensing agency may be contacted by calling toll-free 1-888-700-5330. The home must make the reports to APS and to the licensing agency immediately but not later than within 48 hours of learning of the suspected, reported or alleged incident. ii. In addition to filing the reports as described above, a home must conduct its own investigation and must take immediate steps to prevent further abuse, neglect or exploitation from occurring. The results of the home ' s investigation must be reported to the licensing agency within 5 business days from the date of the initial report of the allegation. The home's investigation and determination must not delay reporting of the alleged or suspected incident to	R232		

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R232	Continued From page 1 Adult Protective Services and to the licensing agency. iii. Incidents involving resident-to-resident abuse must be reported to the licensing agency any time a resident alleges, or the licensee or staff observe or suspect, verbal, physical or mental abuse; sexual abuse, if an injury has resulted; or if there is a pattern of abusive behavior. (A) All resident-to-resident incidents, even minor ones, must be recorded in the resident ' s record. (B) The home must notify legal representatives and families (if permitted) about the incident(s) and must document the report and the plan the home developed to address the behaviors. the following reports with the licensing agency: This REQUIREMENT is not met as evidenced by: Based on Staff interviews and record review there is a failure to report incidents of resident-to-resident abuse involving 2 applicable residents (Resident #1 and Resident #2) to the Adult Protective Services and to the licensing agency. Findings include: During an interview commencing at 3:45 PM on 11/17/25, a Staff member confirmed they recently witnessed an incident of physical aggression between Residents #1 and #2. This Staff stated they heard Resident #2 yelling and swearing in their room. When the Staff responded they observed Resident #2 attempting to punch Resident #1 and stepped between the two Residents to prevent this from occurring. Per Staff, this incident was followed by another incident on the same day during which Resident #2 approached Resident #1 at the dinner table	R232		

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R232	Continued From page 2 and grabbed them by the arm. During an interview commencing at 4:00 PM on 11/17/25, the Staff member who responded to the second incident stated they witnessed Resident #2 grabbing Resident #1's forearm while yelling "No, No, No". This Staff reported the incidents that occurred on this day were preceded by an incident the previous day, when Resident #2 "caught" Resident #1 entering their room. This Staff reported Resident #1 was scared off by Resident #2, ran to their own room, and barricaded the doorway with their body to prevent Resident #2 from coming in. The Staff present during these incidents were unable to confirm the date these incidents occurred, and there is no documentation regarding these incidents in the applicable Resident's record . At approximately 4:30 PM on 11/17/25 the home's court appointed Receiver met with the applicable Staff. Following this meeting, the Receiver confirmed the incidents reported to the Surveyor during the staff interviews conducted on the afternoon of 11/17/25 were not documented in the applicable Resident's records or reported to the Adult Protective Services and the licensing agency. Please refer to tag 360	R232		
R360 SS=G	6.12 Resident's Rights Residents must be free from mental, verbal or physical abuse, neglect, and exploitation. Residents must also be free from restraints and seclusion as described in Section 5.14. This REQUIREMENT is not met as evidenced	R360		

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R360	Continued From page 3 by: Based on staff interviews and record review there is a failure to ensure one applicable resident (Resident #1) remained free of physical abuse by another resident (Resident #2). Findings include: Per record review, Resident #1 is living with advanced Dementia. Per interviews with the Manager of the home and 2 Direct Care Staff conducted on the afternoon of 11/17/25, Resident #1 frequently wanders into other resident's rooms and takes items belonging to others without understanding the impact of this behavior on the other residents. Per record review, Resident #2's diagnoses include Schizoaffective Disorder, Anxiety and a history of a Cerebral Vascular Event (Stroke) resulting in Resident #2 being dependent on use of a wheelchair for mobility due to right side-paralysis, and difficulty communicating verbally (Aphasia). During staff interviews conducted on the afternoon of 11/17/25, the Manager and Staff confirmed Resident #2 becomes upset when people enter their room without permission, and there is a history of verbal conflict between Resident #1 and Resident #2 due to Resident #1 entering Resident #2's room. Per interview with the Manager commencing at 2:10 PM on 11/17/25, on the evening of 10/25/25 Resident #1 reportedly entered Resident #2's room, took a hairbrush, and was later observed by Resident #2 using the hairbrush in the bathroom . When Resident #2 reacted to seeing Resident #1 with their brush, Staff intervened and prevented physical contact between the Residents. Per the Manager, at approximately 11:15 AM on 10/26/25, Resident #2 entered Resident #1's room and was heard yelling. The Manager responded and observed Resident #2 in	R360		

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R360	Continued From page 4	R360		

their wheelchair at Resident #1's bedside, pulling on Resident #1's arm and yelling at them to "get up". Per the Manager, Resident #2 had ahold of Resident #1's wrist and was "yanking [Resident #1] into a sitting position". The Manager stated Resident #1 was sleeping when Resident #2 came into their room, and described Resident #1's as "shaken up" by this incident. The Manager stated they talked Resident #2 into releasing Resident #1's wrist, and removed Resident #2 from Resident #1's room. Per the Manager, approximately 30 minutes later Resident #2 re-entered Resident #1's room and was heard yelling and cursing at Resident #1. The Manager stated when they responded Resident #2 was at the bedside grasping Resident #1's shirt and yanking them around as Resident #1 was attempting to defend their self. The Manager stated they convinced Resident #2 to release their hold on Resident #1's shirt, and removed Resident #2 from the room. The Manager stated they observed buttons were torn off of Resident #1's shirt and Resident #1 has a bruise on their mouth following this incident. The Manager stated Resident #2 attempted to re-enter Resident #1's room a third time, and was wheeled out of the room before additional physical contact was made. The Manager indicated Resident #2's physically abusive behaviors directed towards Resident #1 were a response to Resident #1 entering their room and taking their brush the previous night, and confirmed Resident #2 has a history of verbal altercations with Resident #1 when Resident #1 enters their room without permission. Per record review, Resident #1's current Care Plan, which was updated following the incidents that occurred on 10/26/25, does not identify wandering into other residents rooms and taking other resident's belongings as an issue, or include goals and

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R360	Continued From page 5	R360		

interventions to address this issue. An update to Resident #2's Care Plan dated 10/26/25 identifies a history of resident to resident abuse and altercation with another resident who entered their room and touched their hairbrush.

Per interviews with 2 afternoon/evening shift Staff on the afternoon of 11/17/25, two similar unreported incidents recently occurred between Resident #1 and #2. During an interview commencing at 3:45 PM on 11/17/25, a Staff member confirmed they responded to an incident that occurred between 2:00 PM - 4:00 PM on an unknown date when Resident #2 was heard yelling and swearing in their room. This Staff stated they responded, and upon entering Resident #2's room they stepped between the two Residents as Resident #2 was attempting to punch Resident #1. This Staff described Resident #1 as "really worked up" in response to this incident and stated, "[Resident #1] doesn't understand, and [Resident #2] easily holds grudges". Per Staff interviews, this incident was followed by a second incident on the same day, when Resident #2 approached Resident #1 while they were seated at the dinner table, and grabbed Resident #1 by the arm. During an interview commencing at 4:00 PM on 11/17/25, the Staff member who responded to the second incident stated they witnessed Resident #2 grabbing Resident #1's forearm while yelling "No, No, No". This Staff reported the incidents that occurred on this day were preceded by an incident the previous day when Resident #2 "caught" Resident #1 entering their room. This Staff reported Resident #1 was scared of Resident #2. This Staff also stated, Resident #2 "can hold a grudge for a long time".

At approximately 4:30 PM on 11/17/25 the

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R360	Continued From page 6 Receiver was notified regarding the discovery of the additional incidents during which Resident #2 was physically abusive towards Resident #1, and confirmed they had not been notified regarding the additional incidents. The Staff present during these incidents were unable to confirm the date these incidents occurred; however through information provided during the staff interviews conducted on 11/17/25 and review of staff schedules it was confirmed the incidents described by the Manager and the incidents described by the afternoon/evening shift Staff occurred on different dates and were not the same incident. At 5:06 PM on 11/17/25 the Receiver confirmed Resident #2 was physically abusive towards Resident #1 on multiple occasions. Please refer to tag 232	R360		

Deficiency Statement Plan of Correction (POC)

Survey Date: 11/17/2025

Facility Name: Our House Too

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
232	Monitoring records and interviewing staff by receiver to identify potential issues that were not documented or reported to occur daily in person or via phone interviews	No other residents were identified	12/4/2025	Daily monitoring by Receiver or designee	Receiver
	Receiver to provide staff education on abuse, reporting and scenarios that require reporting.	Other residents to be identified through staff interviews	12/20/2025	Staff education and monitoring by Receiver and RN's, managers	Receiver, Manager and RN
		R232 accepted by LTCM on 12-8-2025			
360	Care plans for Resident #1 and #2 were updated	Receiver audits care plans weekly	12/5/2025	Care plan format has changed. Managers and RN's were educated on the new format and process to update care plans with individualized interventions and goals.	Receiver
	Lock installed on Resident #2 bedroom door.	No other residents were impacted	10/28/25		

	Court Appointed Receiver to provide staff education on supervision of residents, anticipating conflict , and defusing potential situations.	All residents have the potential to be impacted.	12/20/2025	Education for staff	Receiver and Manager to monitor.
		R360 accepted by LTCM on 12-8-2025			