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

February 17, 2026

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 **January 21, 2026.** 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 01/21/2026

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 1/21/2025 the Division of Licensing and Protection conducted an unannounced on-site follow-up survey to determine if the home was back in compliance regarding the deficiencies cited during an investigation conducted on 10/20/2026. The home was determined to be back in compliance with the Residential Care Home and Assisted Living Residences Licensing Rules effective 4/1/2025. In addition to the follow-up survey conducted on 1/21/2026, an unannounced on-site annual survey and an investigation of one complaint and one facility reported incident were conducted on 1/21/2026. The following deficiencies were identified:	R100	Corrective actions for all deficiencies cited accepted by Jo A Evans RN on 2/13/2026 Please see the attached document to review the accepted corrective actions.	
R113 SS=F	5.2.c (7) Uniform Consumer Disclosure- Admit Agreements In addition to general resident agreement requirements, agreements for all ACCS participants must include: A home certified to provide assistive community care services (ACCS) must designate a staff person responsible for case management. Residents must be informed upon admission, and any time there is a change, of the name of the staff person responsible for case management. This REQUIREMENT is not met as evidenced by: Based on staff interview there is a failure to designate a Case Manager for all applicable residents of the home receiving Assistive Community Care Services (ACCS).	R113		

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R113	Continued From page 1 Policies and procedures related to Assistive Community Care Services (ACCS) have not been developed by the home. During an interview commencing at 10:57 AM on 10/21/26 AM the home's Manager was unaware of the requirement to designate staff employed at the home the responsibility for providing case management for the residents of the home receiving Assistive Community Care Services. On the afternoon of 1/21/2026 the court home's court appointed Receiver confirmed a staff member had not been appointed as the ACCS case manager for all applicable residents.	R113		
R194 SS=F	5.10.d (3) Medication Management The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions regarding medication administration and documentation. v. Ensuring that all applicable staff are trained and delegated before the staff are permitted to administer any newly prescribed medication to	R194		

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R194	Continued From page 2 any resident. This REQUIREMENT is not met as evidenced by: Based on staff interview there is a failure to ensure the Registered Nurse teaches designated staff the proper techniques for medication administration during the medication administration training process. Findings include: The home's Medication Administration policy states a Registered Nurse or a qualified, trained designated Staff Member of the facility will administer all medications. This policy also states, "All staff trained by an RN to administer medications will be observed periodically by an RN and such observation will be documented for compliance." Per record review, the Manager of the home is not a licensed Registered Nurse in the state of Vermont. During an interview commencing at 10:57 AM on 1/21/26 the Manager of the home confirmed during the medication administration training process Med Tech trainees are permitted to prepare and administer medications to residents under the Manager's supervision and oversight prior to the home's Registered Nurse delegating the trainees to perform this nursing task	R194		
R206 SS=F	5.10.h (4) Medication Management Medications left after the death or discharge of a resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of	R206		

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R206	Continued From page 3 practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure prompt disposal of outdated medications. Findings include: During a review of the medication storage area conducted on the afternoon of 1/21/26, the following outdated medications were observed to be stored in the home's medication cabinet: a. Trazodone 50 mg tablets expiration date 01/15/2026 b. Benadryl topical analgesic 1 oz tube expiration date 05/2021 c. Lisinopril 10 mg tablets expiration date 11/21/2025 These findings were confirmed by the Manager of the home at 3:15 PM on 01/21/2026.	R206		
R225 SS=D	5.12. b (4) Records/Reports The home must keep and maintain the following records: The results of the criminal record and adult abuse registry checks for all staff: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure a Vermont Criminal Information Center state criminal record check was completed as required for 1 out of 5 sampled	R225		

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R225	Continued From page 4 staff. Findings include Per review of documentation of background checks completed by a sample of 5 staff, a Vermont Criminal Information Center (VCIC) state criminal record check was not completed as required for one contracted staff employed by the home. This finding was confirmed by the court appointed Receiver at 5:14 PM on 1/21/26.	R225		
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	R232		

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R232	Continued From page 5 reporting of the alleged or suspected incident to 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 observation, staff interview and record review there is a failure to report an incident of staff to resident abuse to the Adult Protective Services and the licensing agency within 48 hours. Findings include: The home's policies and procedures governing mandatory reporting of abuse are consistent with the licensing rules. Per record review Resident #1 is living with cognitive impairment due to advanced Dementia, and mental health conditions including Anxiety and Depression. Per observation of video surveillance footage, on the evening of 1/14/2026 Resident #1 approached a Staff member who was looking at a	R232		

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R232	Continued From page 6 cell phone while sitting at the dining room table. As Resident #1 arrived at the table they reached out to pick up a clipboard placed in front of the Staff. The Staff responded by abruptly picking up the clipboard and moving it away from the Resident. Resident #1 then picked up a large cup from the table and attempted to move it to where the clipboard was now placed. The Staff responded by smacking the cup out of the Resident's hand and striking the Resident. The cup and the beverage contained in it traveled in close proximity to the Resident seated across the table from the Staff as it slid across the table and on to the floor. During an interview commencing at 1:58 PM on 1/21/26 the court appointed Receiver confirmed the incident of staff to resident abuse occurring on 11/14/25 was reported to the Adult Protective Services and to the licensing agency on 11/21/25, which is not within 48 hours as required. Please refer to tag 360.	R232		
R358 SS=F	6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law.	R358		

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R358	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure residents' right to privacy related to the unsecured storage of records including personal health information. Findings include: Per observation during a tour of the home commencing at 9:40 AM on 1/21/2026, binders used to hold paper health records for residents of the home were observed to be unsecured and visible in the home's laundry area. This finding was confirmed by the Manager of the home during the tour conducted on the morning of 1/21/2026.	R358		
R360 SS=D	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 by: Based on observation, staff interview and record review there is a failure to ensure one applicable resident (Resident #1) remained free of abuse by staff. Findings include: The home's policies and procedures governing abuse are consistent with the licensing rules. Per record review Resident #1 is living with cognitive impairment due to advanced Dementia, and mental health conditions including Anxiety and Depression. Resident #1 requires staff for	R360		

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R360	Continued From page 8 assistance with activities of daily living. Per observation of video surveillance footage, on the evening of 1/14/2026 Resident #1 approached a Staff member who was looking at a cell phone while sitting at the dining room table. Two other residents were seated at the table in wheelchairs. As Resident #1 arrived at the table they reached out to pick up a clipboard placed in front of the Staff. The Staff responded by abruptly picking up the clipboard and moving it away from the Resident. Resident #1 then picked up a large cup from the table and attempted to move it to where the clipboard was now placed. The Staff responded by smacking the cup out of the Resident's hand and striking the Resident. The cup and the beverage contained in it traveled in close proximity to the Resident seated across the table from the Staff as it slid across the table and on to the floor. The Staff stood up, and per video review appears to be yelling as they walk past Resident #1 with raised arms, then threw their cell phone across the kitchen counter. During an interview commencing at 1:58 PM on 1/21/26 the court appointed Receiver confirmed Resident #1 was not free of abuse by a staff member on the evening of 11/14/2025.	R360		
R401 SS=F	9.1.a Environment The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This includes outdoor areas that are used by residents. This REQUIREMENT is not met as evidenced by:	R401		

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R401	Continued From page 9 Based on observation and staff interview there is a failure to ensure care in a safe environment related to the condition of baseboard heaters in 3 areas of the home. Findings include: Per observation during a tour of the home commencing at 9:40 AM on 1/21/26 the metal end caps of the baseboard heaters in 3 areas of the home routinely traversed by residents of the home including the dining room, one resident room, and in the front hallway were observed to not be tightly secured to the heater. The exposed metal edges of the end caps were observed to be protruding into areas accessible to residents, which is a risk for injury. This finding was confirmed by the court appointed Receiver.	R401		

Deficiency Statement Plan of Correction (POC)

Survey Date: January 21, 2026

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
R113 Plan of Correction accepted by Jo A Evans RN on 2/13/2026.	The manager is designated as the ACCS Case Manager.	Current ACCS residents were identified and notified of the Case Manager's name.	2/14/26	The manager's name has been added to the ACCS agreement.	Receiver
				Education was provided to the Manager on the role of ACCS Case Manager by the Receiver	
R194 Plan of Correction accepted by Jo A Evans RN on 2/13/2026.	There are no current medication technicians trained under the deficient practice.	No residents were negatively impacted	2/14/26	Education provided to the Manager on the policy for training new medication Techs by the Receiver. The policy was updated to reference passing meds under supervision of manager.	Receiver
R206 Plan of Correction accepted by Jo A Evans RN on 2/13/2026.	Expired medications were destroyed.	No residents were negatively impacted	2/14/26	The manager will inspect medications weekly to ensure expired medications are removed. The receiver will conduct random audits of medications to ensure the process is followed.	Manager Receiver
R225 Plan of Correction accepted by Jo A Evans RN on 2/13/2026.	The VCIC criminal record check was completed with no findings. A National criminal record check	No residents were negatively impacted.	1/21/2026	Receiver to verify Agency staff have complete VCIC checks in addition to the National background check.	Receiver

	had been completed prior to work at the home.				
R232 Plan of Correction accepted by Jo A Evans RN on 2/13/2026.	The incident was reported by the Receiver.	No residents were negatively impacted.	2/14/26	Staff received education on reporting responsibilities .	Manager
R358 Plan of Correction accepted by Jo A Evans RN on 2/13/2026	Binders were relocated to a secure location	No residents were negatively impacted.	2/14/26	Signage was posted in the laundry area regarding storage of PHI. Staff education on PHI provided by Receiver	Manager Receiver
R360 Plan of Correction accepted by Jo A Evans RN on 2/13/2026	The caregiver was terminated.	No other residents were impacted	2/1/26	Education on resident abuse was conducted at the time of the incident by the Receiver and is reviewed at every monthly staff meeting.	Receiver
R401 Plan of Correction accepted by Jo A Evans RN on 2/13/2026	Radiators were repaired or replaced	No residents were negatively impacted and there have been no injuries to residents due to the radiators.	Repairs complete by 2/14/26 Replacement units date will depend on ability to obtain new units but no later than 3/16/26	Maintenance repairing or replacing the 3 radiators. Manager to round monthly to inspect radiators to ensure they do not pose a risk to residents.	Manager Receiver