

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0377	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/03/2009
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE TOO RESIDENTIAL CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 69 1/2 ALLEN 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 onsite complaint investigation was conducted on 06/04/09 by the Division of Licensing and Protection. As a result of the investigation the following deficiency was cited.	R100	R 100 -  this investigation was prompted by our call to APS.	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.18 Reporting of Abuse, Neglect or Exploitation  5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report allegations of suspected resident abuse within the time frames specified at 33 V.S.A., Chapter 69, Subchapter 1. (Resident # 1). Findings include:  1. Per resident record review and facility internal investigation, on 05/24/09 at approximately 3:30 AM, Resident #1 became agitated and difficult to redirect by the 2 staff members working the night shift. The resident proceeded to enter a resident's room and was observed hitting a resident who was in bed. The 2 staff members proceeded to remove the resident from the room and later in the report describes "we both took (the resident) from under both armpits and with each of our other hands held our hands on (the resident) to	R206	R 206 - Initially This event was explained as a resident to resident episode - OUR INVESTIGATION IS when concerns with staff and their handling of the event that prompted our call to A.P.S. -	5/09

Division of Licensing and Protection

*Paula [Signature]*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

owner/administrator

(X6) DATE

7/6/09

STATE FORM

8899

BNWW11

If continuation sheet 1 of 2

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R206	Continued From page 1 prevent s/he from punching us, just applying pressure when s/he lifted to hit.....". Per Interview on 06/03/09 at approximately 12 noon, the manager stated s/he was made aware of the incident involving Resident #1 and observed bruises on Resident's #1's arms on the morning of 05/24/09. The manager also confirmed it was not until 05/28/09 a report of alleged abuse was made to Adult Protective Services which was not within the required 48 hour time period.	R206	<i>The managers of our house acknowledge that suspected A, N or E Need to be reported within 48 hours and will maintain that practice.  In the future all concerns will be called into ARs within 48 hours.</i>	5/09
		7/16/09	R 206 POC Accepted O Odeh, RN	

