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

October 16, 2018

Ms. Nancilee Kennedy, Manager
Bromley Manor
2595 Depot Street
Manchester Center, VT 05255

Dear Ms. Kennedy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 5, 2018.** 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
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0657	A. BUILDING: _____ B. WING _____	C 09/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROMLEY MANOR	2595 DEPOT STREET MANCHESTER CENTER, VT 05255

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R100	Initial Comments: An unannounced on-site relicensing survey and a compliant investigation was conducted by the Division of Licensing and Protection on 9/4 and 9/5/18. The findings include the following:	R100		
R132 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 Special Care Units 5.6.c A home that has received approval to operate a special care unit must comply with the specifications contained in the request for approval. The home will be surveyed to determine if the special care unit is providing the services, staffing, training and physical environment that was outlined in the request for approval. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by the Registered Nurse (RN) Manager, the facility failed to comply with the specifications outlined in the approved request to operate the Special Care Unit in the areas of staffing and staff training. The findings include the following: Per review of the facility license, it includes a license to operate an eleven (11) bed Special Care Unit (SCU). Per review of the approved request for licensure, prepared by the facility, identified they would comply with the following specifications: 1. "Staff Qualifications: Each Resident Attendant (RA) will complete eight hours of training through	R132		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mancilee Kennedy — TITLE: RN/Manager — (X6) DATE: 9/30/2018

R132 - R999 POCs accepted 10/11/18 mbertrand RN/mmc with addendums.

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R132	Continued From page 1 the Alzheimer's Association "Cares" outline training program. This will consist of two modules; Dementia Basics and Dementia-Related Behaviors, as well as demonstrate skills both in personal care, interaction and approach with the residents before working independently. Bromley Manor will partner with the Alzheimer's Association for ongoing education and incorporate the education into monthly in-services with the SCU staff, which will provide 12 hours annually of dementia-specific training." Confirmation was made by the Registered Nurse (RN) Manager on 9/5/18 at approximately 11 AM, that staff have had some Dementia Basics education, but the Alzheimer's Association "Cares" training program is no longer available. The facility has not developed an education program for staff that would meet the approved requirement. The RN also confirms that there has been no amendment to the Bromley Manor Special Care Unit to the licensing agency. 2. "Staffing will be as follows, using a 4 (residents) to 1 (staff) ratio: 1st shift, 6:30 am to 2:30 pm - 2 Resident Attendants (RA's) and one (1) Medication Technician (MT) 2nd shift, 2:30 pm to 10:30 pm - 2 Resident Attendants (RA's) and one (1) Medication Technician (MT) 3rd shift, 10:30 pm to 6:30 pm - 1 Resident Attendant (RA) and one (1) Medication Technician (MT)" The RN Manager confirms that the SCU currently has a census of 6 residents. Per review of the staff schedule for the SCU,	R132	el am working with Rutland VT area training coordinator from RNs to schedule inservice training. — CARES Program is now available as well and will have on line courses available for all staff to be completed at Bromley Manor by 1/15/2019. — And will be required for new hires - in addition to the 2 hour dementia related training completed previously, there will be 10 additional hours completed by 1/15/19 — 1/15/19	

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R132	Continued From page 2 documentation identifies that during the 3rd shift, there is 1 RA and 1 MT assigned to the unit. That staff, also have the responsibility to conduct rounds and respond to resident needs for the additional thirteen (13) residents, who reside in Residential Care Home (RCH) The Manager confirms on 9/5/18 during interview that the SCU has only one (1) RA on the 3rd shift for a period of approximately 1+ hours depending on RCH resident needs at any given night.	R132	Bromley Manor will continue to maintain a ratio of one care provider per 4 SCU residents. We would like to amend wording of SCU licencing policy to reflect 1:4 ratio, stating we will have a minimum of 2 CA's on unit at all times, one of whom may also be trained and designated med tech. From 7am - 4pm in week days we have auxiliary staff (dietary, maintenance, activities) trained and available to assist care staff as needed. — On 3rd shift, staff is no longer rounding on RCH residents - There is a communication system in place with Life line devices per resident for emergencies and telephone communication for residents to call staff. Resident #6 has a locked metal box in her room containing all medications, including OTC medications	
R155 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by the Registered Nurse (RN)/Manager, the facility RN failed to assume responsibility assuring the security of medications left at the bedside for residents who choose to self-administer prescription and over the counter medication, (Residents #4, #5 #6, #7, #8 and #9). The findings include the following: Per observation during the facility tour in the presence of the RN Manager the following was identified: 1. Resident #6 had the following medications unsecured, found on the shelf on a table next to the television: Vitamin D-3 400 International Units	R155		

In addition, owner live on site and are available to support staff in the event of an emergency - As our population increases we intend to hire additional staff.

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R155	Continued From page 3 (IU) expired on 11/2014, 3 bottles partially used Myrbetriq 25 mg tablets, Toprol XL 50 mg (2 bottles) partially used, 2 bottles partially used Lisinopril 10 mg tabs with one bottle identifying a used by date of 8/8/18, 3 loose pills unidentifiable sitting on a lid of a card-board box, Cephalexin 250 mg capsules partially used, bottle of partially used Vitamin D-3 100 IU, Aspirin 81 mg tablets partially used, Iron 65 mg tablets with no lid and an expiration date of 10/2013, Bactrium DS 6 tablets with no lid and instructs the resident to take daily, Lopermide Hydrochloride 2 mg tabs partially used with an expiration date on 3/2018, Systane eye drops lubricant expired on 1/2017, Visine eye drops expired on 2/2015 and Normal Saline nose drops. 2. Resident #7 had medications located in two separate drawers in the bureau. The medication prescribed are not in their original containers. As per resident's prefcrence s/he has color coated the lids of the bottles and therefor s/he places the medications in the bottles, that identify the various times for administration. The bottles the medications are placed in, have dates that identify the medications have expired; 3. Resident #8 has various prepared medications in day containers placed by her/his family member who is a nurse. Medications are stored/ on the second shelf of a table; 4. Resident #9 has the following medications stored in his/her bathroom counter: 2 partially used bottles of Synthroid 75 mcg each, 2 partially used bottles of Hydrochorothiazide 12.5 mg tablets, partially used bottle of Losartin 50 mg tabs, Amoxicillin 500 mg tabs partially used instructed to take until gone (resident confirms s/he missed one day), multi dose/partially used	R155	RN/Resident weekly med reviews as stated above Resident #8 has discharged to home as planned All self medicating residents approved through RN assessment and MD orders, will have lock box, provided by Bromley Manor, for storage of medications, and will have weekly reviews of above by RN/Med staff to ensure compliance - Some of these above conditions are in place at this time Resident #9 will keep medications in locked box provided by Bromley Manor with weekly medication reviews with med tech or RN to ensure compliance	

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R155	Continued From page 4 bottles of Advil Tylenol and Multi-Vitamins. There are numerous empty over the counter medication bottles that need to be discarded that are also stored on the counter top; 5. Resident #4 has a bottle of Tylenol 500 mg tablets at the bedside; 6. Resident #5 has a partially used bottle of Creo at the bedside; Per review of the Admission Agreement, Section g identifies Medication Management: ["As long as you are able to direct the administration of your medications in accordance with state regulations we will provide you with necessary assistance such as reminding you of medication times or helping you take medication"]. The RN Manager confirms on 9/4/18 at approximately 11:30 AM that the staff do not follow up ensuring that medications are taken, nor are they reviewed to ensure that the resident is taking the medication as per physician orders, nor can the manager confirm that the resident room doors are locked consistently. See also R175.	R155	Resident # 4 has agreed for med staff to administer all medications, to include OTC's - ALL medications removed from her room at this time - RN will review with each self medicating resident all medications kept in locked box in bedroom weekly - Counts will be done to ensure medications taken as prescribed, and will continue to monitor for S.O.S R/T problem- lists, up to date (no expired) medications -	
R161 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures.	R161		

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R161	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure that medications are handled according to the manufacturers requirements and that staff are fully trained in the proper storage of Insulin Pens for 2 applicable residents, (Resident #5 and Resident #6). The findings include the following: Per review of the Medication Administration Records and Physician Orders for both Resident #5 and Resident #6, identify Insulin administration via injection using an Insulin Pen. Recommendation for Insulin storage after use identifies that the pen may be stored at room temperature for 28 days. Per inspection of both pens used during administration on 9/4/18 and 9/5/18, neither pen has any identification as to when the pen was first put in use. Therefore, it is undetermined the length of time the Insulin Pen has been used for administration of the Insulin, from either pen, for Resident #5 or #6. The Registered Nurse Manager confirmed on 9/4/18, that s/he never considered the need to identify when the pen was first used.	R161	Although we were calculating days of dosing based on units ordered, we now mark all insulin pens with tape/Marker when removed from refrigerator with date and time and staff has been advised of above —	
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or	R171		

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R171	Continued From page 6	R171		

representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:

(1) Documentation that medications were administered as ordered;
(2) All instances of refusal of medications, including the reason why and the actions taken by the home;
(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;
(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and
(5) For residents receiving psychoactive medications, a record of monitoring for side effects.
(6) All incidents of medication errors.

This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed by the Registered Nurse (RN) Manager, the facility failed to assure that 2 applicable resident sampled, who receives psychoactive medication, is monitored for side effects (Resident #1 and #3). The findings include the following:

1. Per record review, Resident #3 has a physician order dated 1/23/18, for Seroquel 12.5 milligrams (mg.) by mouth (po) every four (4) hours as needed for agitation, hitting and yelling. Per review of the Medication Administration Record (MAR), identifies that in the month of July 2018 the resident received the medication on 7 different occasions, August 2018 s/he received the medication on 8 different occasions and to date in the month of September 2018, the

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R171	Continued From page 7 resident has not required any of the Seroquel. Seroquel is an antipsychotic medication that may cause serious irreversible side effects such as, but not limited, to muscle movement that can not be controlled (often in the lips, tongue, jaw or legs). The RN manager confirms on 9/5/18 at approximately 1 PM, that there is no evidence that residents who receive psychoactive medications have documentation identifying that side effects are monitored. 2. Per record review, Resident #1 has a physician order dated 6/18/18, for Seroquel 12.5 mg. po at bedtime for anxiety/agitation and Seroquel 25 mg po two times a day for anxiety/agitation. Seroquel is an antipsychotic medication that may cause serious irreversible side effects such as, but not limited, to muscle movement that can not be controlled (often in the lips, tongue, jaw or legs). The RN manager confirms on 9/5/18 at approximately 1 PM, that there is no evidence that residents who receive psychoactive medications have documentation identifying that side effects are monitored.	R171	Previously, all residents receiving psychotropic medication pcn have had medication information sheets listing uses of, and possible side effects of these medications on MAR, In addition, we have added standardized ATMP forms for RN monthly monitoring for potential side effects, and staff has been instructed to report any potential side effects to RN.	
R172 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10-h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label.	R172		

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R172	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interviews, the facility failed to ensure that all medications are labeled in accordance with current accepted professional standards of practice for 1 of 5 residents observed during a medication administration audit, (Resident #4). The findings include the following: Per observation during a medication administration with the Medication Technician, Resident #4 has a physician order for Gabapentin 300 milligram (mg.) capsules twice a day (bid) by mouth (po), dated 8/8/18. Per review of the medication administration record (MAR) dated 8/21/18, instructs the Medication Technicians to assist with administration of Gabapentin 300 mg po three times a day. * Per review of the Bingo Card (card holder for the medication), is labeled Gabapentin 300 mg. capsules take 1 capsule twice a day. The Registered Nurse Manager on 9/4/18 at approximately 4 pm, confirms the label and the physician order are incorrect and do not match what is prescribed *	R172	Pharmacies will provide updated stickers for labeling medications if MD instructions change - MAR's will continue to be updated as soon as changes occur -	
R175 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration	R175		

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R175	Continued From page 9	R175		

may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission.

This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by the Registered Nurse (RN) Manager, the facility has failed to provide 10 sampled residents, who choose to administer their own prescription and over the counter medications, with a secure storage space to prevent unauthorized access to the resident's medication, (Resident # 4, #5, #6, #7, #8, #9, #10, #11, #12 and #13). The findings include the following:

Per facility tour in the presence of the RN Manager, on 9/4/18 beginning at approximately 9:30 AM and concluded at 11:45 AM, both prescription and over-the-counter medications were discovered in the following Resident's Rooms: Resident # 4, #5, #6, #7, #8, #9, #10, #11, #12 and #13. The medications were located in visual view, stored on bedside tables, bathroom counters and bureau draws. Some of the medications were identified as outdated, bedroom doors unlocked and a number of prescription medications were not necessarily in the original bottles.

Per discussion with the RN Manager confirmation was made that the facility does not provide a secure locked space for each individual resident who is able to self administer medications. The RN also confirms that since the resident takes their own medication the facility staff do not follow

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R175	Continued From page 10 up with the resident if the medication is taken, if the medication needs to be discarded and the RN cannot confirm that the resident bedroom doors are consistently locked Per review of the Admission Agreement, Section g. identifies Medication Management: ["As long as you are able to direct the administration of your medications in accordance with state regulations we will provide you with necessary assistance such as reminding you of medication times or helping you take medication"].	R175	All residents deemed able to self medicate by RN assessment and MD order will be provided with locked metal box to store medications in bedrooms - medication will be checked with each resident and med tech or RN to make sure no outdated medications, medication is stored properly and being taken as prescribed.	
R246 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by the main cook, the facility failed to ensure that all milk products served and used in food preparation are free of spoilage. The findings include the following: Per observation during the noon meal and during inspection of the dietary department, the surveyor discovered a partially used quart of whole milk dated 9/3/18 and 1gallon of skim milk partially	R246		

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R246	Continued From page 11 used dated on 8/13/18, in the beverage refrigerator. The cook confirmed on 9/4/18 at approximately 12:30 PM, that both the skim milk and the whole milk were outdated. The owner was also present during the tour and confirmed that the whole milk should be discarded.	R246	All dietary staff has been trained to monitor expiration dates of all foods and beverages used in food preparation for service and resident consumption, and to discard foods/beverages prior to expiration dates -	9/18/18
R249 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by the main cook the home failed to assure that food handling and storage techniques are consistent with safe food handling practices. The findings include the following: Per dietary department tour on 9/4/18 at approximately 1:15 PM the following foods were found to be stored in the refrigerator unsafely: -Uncooked Sword Fish dated 8/21; -Foil covered meat, confirmed to be turkey bacon, unlabeled and not dated as to when it was placed in the foil; -Multiple plastic wrapped grated and chunk cheeses with no label or date as to when they were opened; -A plastic container of tartar sauce with no date; -A plastic container with no identification of what the product is or when it was placed in the	R249		

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R249	Continued From page 12 container. The above items were confirmed by the main cook as unidentifiable or unlabeled. S/He also confirms that open foods are discarded after 7 days.	R249	Staff has been instructed to label and date clearly all foods that have been opened and are stored —	9/18/18
R251 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by dietary staff the facility failed to store food as to protect from dust, insects, rodents and all sources of contamination. The findings include the following: Per tour of the main dietary department on 9/4/18 at approximately 1:15 pm the following was identified: -A 25 pound bag of corn meal open in use and unsealed. No date as to when it was opened; -Multiple assorted boxes of dry cereal, ranging from 12 ounces to 2 pounds, found partially used, unsealed and not dated as to when they were opened. The main cook confirmed at the time of the tour that the products were not stored properly.	R251		
R252 SS=F	VII. NUTRITION AND FOOD SERVICES	R252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0657	A. BUILDING: _____ B. WING _____	C 09/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROMLEY MANOR	2595 DEPOT STREET MANCHESTER CENTER, VT 05255

(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
R252	Continued From page 13 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to assure that all equipment is kept clean. The findings include the following: Per tour of the dietary kitchen, in the presence of the main cook on 9/4/18 at approximately 1:15 PM, the following was identified; -The main hood that is located above the large cooking stove was found to have visible, accumulated dust and grime. The sticker on the exterior hood labeled Bromley Brook School identifies that the next inspection is due 8/2011, Administration cannot confirm when the last inspection was conducted. -The convection oven located to the right of the main cooking stove has visual dust, grime and crumbs accumulated on multiple surfaces; -The microwave oven has accumulated splatters and food particles on the inside surfaces; -The table that stores all clean dishes and bowls, located below the service line, was found to have a greasy surface, visible dust, grime and crumbs. The main cook confirms during this tour that there are no cleaning schedules and that the above discovered concerns need attention.	R252	All dry foods will be labeled, dated and sealed — Estimates have been obtained from 3 hood cleaning services - Hood is scheduled to be cleaned on Oct 26, 2018 — A cleaning schedule is in place to clean all kitchen and surfaces —	9/18/18 10/26/18 9/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R254	Continued From page 14	R254		
R254 SS=C	VII. NUTRITION AND FOOD SERVICES	R254		

7.3 Food Storage and Equipment

7.3.d All equipment, utensils and dinnerware shall be in good repair. Cracked or badly chipped dishes and glassware shall not be used.

This REQUIREMENT is not met as evidenced by:
Based on observation and confirmed by staff interview the facility failed to maintain the freezer in the dietary department in good repair and a sticker on hood above the stove in the kitchen identifies that the equipment was due for inspection 8/ 2011. The findings include the following:

1. Per observation of the dietary department on 9/4/18 at approximately 1:15 PM the freezer was discovered to have built up ice accumulation along the entrance of the door and along the inside on the left side of the doorway. The door is difficult to open and close tight due to the accumulation of ice. Temperature logs are checked daily and identify appropriate parameters for freezing food, however the main cook confirms that s/he chips away at the ice build up 1-2 times a day. The owner also confirms during the tour, that they have contacted a vendor approximately 2 weeks ago, but have not had any response/service to date on the freezer.

2. The main hood that is located above the large cooking stove was found to have visible, accumulated dust and grime. The sticker on the exterior hood labeled Bromley Brook School identifies that the next inspection is due 8/2011.

Freezer door has been repaired - There is no current ice accumulation, freezer temperatures are monitored and recorded daily — 9/17/18

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	0657	A. BUILDING: _____ B. WING _____	C 09/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R254	Continued From page 15 Administration cannot confirm when the last inspection was conducted.	R254	Once cleared on 10/26/18 the hood will be scheduled for inspection ——	
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by management, the facility failed to conduct fire drills on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. The findings include the following: Confirmation was made by the facility Manager and one of the two owners on 9/4/18 at approximately 11:30 AM, that the facility has not conducted any fire drills since opening on 1/11/18. The first resident moved in on 1/15/18.	R302	Bromley Manor scheduled and met with three local fire chiefs to review facility fire and Emergency plan - copies of same have been distributed to residents and staff, meetings with residents of each wing, and all staff, have been conducted with outline of proper procedures - Mock drills are taking place to insure the calm implementation of above procedures — 9/19/18	

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R999	Continued From page 16	R999	cont'd fr 16- Fire Dept has offered and will be conducting demonstrations of fire extinguisher use with staff 9/18/18	
R999 SS=C	MISCELLANEOUS 4.14.f Survey/Investigation The home shall make written reports resulting from inspections readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. The Home must post a notice of the availability of such written reports. If a copy is requested and the home does not have a copy machine, the home must inform the resident or member of the public that they may request a copy from the licensing agency and provide the address and telephone number of the licensing agency. Based on observation and confirmed by the facility Manager, the home failed to have the Investigation results, conducted on 2/21/18, available to residents and/or the public. The findings include the following: Per facility tour in the presence of the Manager, on 9/4/18 at approximately 8:55 AM, investigation results conducted on 2/21/18 could not be located. The Manager confirmed at the time that the results are kept in a folder in his/her office and is available when asked for. The Manger also confirmed that s/he was not aware that the results should be posted and available without asking for them.	R999	Copies of inspection reports are now posted 9/18/18 (hanging in process) on bulletin board near dining room (2nd fl) to be readily available to public, residents and staff.	

Division of Licensing and Protection
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Waterbury, Vermont 05671-2060
802-241-0480
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Plans of Correction update
10/05/2018
Bromley Manor
2595 Depot street
Manchester Center, VT 05255
802-768-8134.
Fax: 802-768-8058
nurse@bromleymanor.org

10/05/2018

Dear Ms. Cota,

Enclosed please find updated information regarding survey plans of correction as requested

R132:

The date for completion of training for plan of correction has been updated. The 10 module CARES training program to include Dementia Basics and dementia Related Behaviors will be completed by all SCU staff by 11/05/2018. Facility RN/Manager will supervise and document the above staff training. Documentation of completed above training will be kept in each applicable employee's file.

Staffing on SCU will continue to reflect 1 care provider per 4 residents. There will be a minimum of 2 care providers on SCU at all times 1st and 2nd shift, one of whom may be a designated med tech. A designated med tech will be present on every shift. 3rd shift staff will have minimum of 2 care providers on SCU, one of whom will be designated med tech. RCH residents will continue to have room specific emergency alert device for emergencies and will continue to have non emergency telephone number for SCU staff for needs that arise 11pm-7am. Owners will continue to be available for staff support in the event that a care provider must respond to RCH staff that would cause 1 care provider to be off SCU for any length of time. Staffing will be monitored by designated scheduler and manager will be informed of any scheduling conflicts. This is currently in place at this time. Staff and residents are aware of communication and emergency systems. Each resident has been taught the use of emergency system and call

system. All new staff members will be trained regarding above. New RCH residents will be informed of above.

R155

1) Resident #6 obtained a lock box on 09/08/2018. All medications are kept in this box. Med staff checks daily with resident that medications are secured in lock box. RN will meet with resident on a weekly basis to review medications, check expiration dates of medications, do weekly med counts to verify medications taken as prescribed. RN will document compliance weekly in resident nursing note. RN is encouraging resident to have all medications delivered in "medication on time" blister packs prepared in pharmacy per provider order. This will be in place for next order cycles by 11/05/2018 and will be ongoing.

2,3,4,6: Resident's #5,7,9 will be provided with lock box to secure medications in bedrooms. Med staff will check daily with above resident's to make sure that medications are secured in lock box. RN will meet with each resident weekly to review medications, check expiration dates of medications and do weekly counts of medication to verify that medications are being taken as prescribed. RN will document compliance in resident specific nursing note. RN is encouraging residents to have all medications delivered in "medication on time" blister packs prepared in pharmacy per Provider order. This will be in place for all current residents deemed through RN assessment and provider order to self medicate, and will be in place upon admission for new residents once current medication supply they arrive with is due for reorder.

Resident #4 has agreed to have all medication, including OTC medication, administered by med staff. All medications were removed from resident room on 09/07/2018.

Resident "8 discharged to home on 09/24/2018 as planned.

161 5.10:

Resident's #5 using insulin pens have above in medication refrigerator in med room. When insulin pens are removed from the refrigerator for resident specific use, pens are taped and dated. Med staff has been instructed to do above. RN will monitor that insulin pens are disgarded no later than 28 days of non refrigerated use. Resident #6 keeps insulin pen in refrigerator until use. RN has met with resident who verbalized good understanding of above, and has agreed to date pens as they are removed from refrigerator for use. RN will monitor this weekly upon weekly medication checks with resident. Any resident requiring the use of insulin pen will be monitored as above by RN, and RN will document in resident specific nursing note re compliance with above. The above has been put into practice as of 09/06/2018.

All residents deemed through RN assessment and provider order able to self medicate will be met with weekly by RN to make sure medication is being taken appropriately. RN will monitor all self medicating residents for wellness r/t diagnosed, and chart weekly on above, as of 10/01/2018.

R171:

All residents receiving psychotropic prn medication will continue to have in resident specific MAR medication information sheet listing use of and potential side effects of psychotropic medication. This has been in place and ongoing. Staff is trained to report any potential side effects of prn psychotropic medication to RN. Each resident receiving prn psychotropic medication has AIMS form in MAR. RN monitors and documents AIMS on a monthly basis, effective 10/01/2018.
R172: Resident #4 received new supply of gabapentin from pharmacy with current provider order indicating correct dosage. Any medication order changes will be reviewed by RN and RN will have updated or changed order direction labels sent from pharmacy as orders change. Pharmacy had been contacted on 09/06/2018 for correct labels prior to new supply being delivered.

R246:
Dietary staff has been instructed by management and staff chef to monitor expiration dates of all food and beverages used in resident food service, and to discard the above on or before expiration dates. Staff chef will monitor above. Dietary staff has been instructed to date and label all foods that have been opened and stored. Chef will monitor above and make sure that food in facility labeled containers is discarded within 7 days of labeling and dating. This is effective as of 09/06/2018.

Dry foods will be appropriately stored, labeled dated and sealed once opened. Staff chef will monitor above daily. Effective 09/06/2018.

There are Hood cleaning will be documented by staff chef to reflect dates of cleaning and maintenance. Hood cleaning is scheduled for 10/26/2018 and will be documented by chef and kept in dietary notebook.

A cleaning schedule and check list is in place for cleaning all kitchen and food prep surfaces. This will be documented daily by dietary staff as tasks are completed and chef will monitor and keep documents in dietary notebook.

Chef will be responsible for daily temperature checks of freezers and refrigerators and will monitor and record in dietary notebook daily.

R302:
On 9/19/2018 local fire chiefs were reviewed fire safety and emergency plans

With Bromley Manor owners and several staff members. On 10/5/2018 the first resident staff mock drill was conducted by RN on Bwing. Fire department chiefs will conduct staff inservice in use of fire extinguishers to be scheduled 10/2018. Fire safety drill log will be kept in notebook and RN, Managers will document fire safety drills to include staff present. RN will monitor and document fire drills.

All survey reports are now in labeled folder on bulletin board in public hallway near dining room and available for viewing as of 09/06/2018. RN Manager will ensure that all survey results are posted as above and available.