

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

December 17, 2021

Ms. Mary Norman, Manager Bromley Manor 2595 Depot Street Manchester Center, VT 05255

Dear Ms. Norman:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 30**, **2021**. 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

	Licensing and Prote	ction (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION (X3) D.	ATE SURVEY OMPLETED
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	1	
MIDIEMIO	001112011011				С
		0057	B. WING		08/30/2021
		0657		and hong	
NAME OF PR	OVIDER OR SUPPLIER		DRESS, CITY, STAT	E, ZIP CODE	
	2	2595 DEPC	OT STREET	and the same of th	
BROMLEY	MANOR	MANCHES	TER CENTER,	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	JEACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
IAG	Metallological action			1a Promley manor has re writte	an an
R100	Initial Comments:		R100	1a. Bromley manor has re-writted the orientation program to include Resident Rights,	e;
	was conducted by t	n-site complaint investigation the Division of Licensing and		Abuse/Neglect/Exploitation, HIP Communication with Elders,	
1	Protection on 8/24/	2021 and completed on	1	Observing Professional Boundar	100,
	8/30/21. There wer result of this invest	e regulatory findings as a		Bloodborne Pathogens, Handwashing, Safe Linen Handl	ing
	result of this livest	igation.		Covid 19, Back Safety,	"'g,
D400	A DECIDENT CAS	RE AND HOME SERVICES	R132	Fire/Evacuation, Emergency	
SS=E		REAND HOME SERVICES		Response, Alzheimer's Caregivi	na
		5	Ţ.	and Preventing Pressure Ulcers	
	5.5 Special Care	Units		New Employees will complete w	
1			V	the five training days and all	
1	5.6.c A home tha	t has received approval to	1	employees will complete annual	
1	operate a special	care unit must comply with the	1	All Current Employees will comp	
	specifications con	tained in the request for	1	the new Orientation Program wit	inin 31
	approval. The no	me will be surveyed to pecial care unit is providing the		3 months with a date of complete	ion 2022
1	services staffing.	training and physical		of March 31, 2022.	
1	environment that	was outlined in the request for	1	4h An Education Bindaryuga	
1	approval.		1	1b. An Education Binder was created to show education provi	dod
				monthly as well as individual trai	
		ENT is not met as evidenced	1	files on each employee was crea	ated 31,
	by:	terview and record review the		by October 31,2021	2021
	Based on start in	rovide dementia specific training	1	2, 00.0001 01,2021	2021
	and staff to reside	ent ratios that were outlined in		1c. Alzheimer specific training v	vill
6.	the facility's Spec	cial Care Unit (SCU) request for	1	be provided on going and each	
	approval. Finding			employee working on the Memo	ry
		2 0		Care Unit will complete the 8 ho	
1	1. Per review of	the SCU application the facility		of Dementia Training. Current	20
1	reported that "ea	ich RA (Resident Attendant) will		Employee will complete within 3	
	Complete eight h	ours of training through the ociation Cares online training	1	months with a completion date of	
	program This w	ill consist of two modules;	E	March 31, 2022 and annually.	
	Dementia Basica	s, and Dementia-Related		employees will complete the 8 h	ours 31
	Rehaviors, as w	ell as demonstrate skills both in		of training with 3 months of hire.	2022
	personal care, in	nteraction, and approach with the		NA - (lab and lab 20 to a store - from 0	1
	resident before	working independently. Bromley	1	Monthly audits will be done for the	nree
	Manor will partn	er with the Alzheimer' Association	1	months and then quarterly.	
1	for ongoing edu	cation and incorporate the			

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

5BD011

Division o	of Licensing and Protect	ction				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SI COMPLE	TED
		0657	B. WING			0/2021
NAME OF PI	ROVIDER OR SUPPLIER	2595 DEP	DRESS, CITY, STAT OT STREET STER CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
R132	education into month which will provide 12 specific training." Per review of RA #1 dementia specific training specific training recorded for the specific training recorded for the specific training provided since their Of the 4 RAs who all was no documented specific training was per interview with a at 5:50 PM s/he has file and track staff trobeen an organized to confirmed that the 4 work on the SCU, a required trainings. 2. Per review of the "staffing will be as file."	's training records 9 hours of ining was provided on there was no evidence that my dementia specific training or was no other documented esent for 2020 or 2021. Taining records had no mentia specific training dates of hire. The assigned to the SCU there is evidence that any dementia provided in 2021. RA/Med Tech on 8/24/2021 arecently taken responsibly to aining, and there had not filling system. The Med Tech RAs who were reviewed do and they did not have the SCU request for approval collows, using a 4 to 1 ratio: 1st	R132	Of the nine residents, one is in need of placement on the schedule as she is a Hospic Client who could live on a different unit. Of the nine residents only 3 are on the uall the time and the others a two of three meals in the madining room and attend activities/gatherings off the unit haddition to the two staff members on the unit there a periipheral staff, activity, administrative, maintenance dietary, nursing staff and housekeeping utilized as we two staff from the assisted liside. In speaking with an administrator from another community, she reports have the same staff for 21 special residents. Bromley manor we request an amendment to the staffing statement by December 21,2021	unit unit uttend ain unit. are ell as iving il care will ne	Decembe 31, 2021
	shift, 6:30 am to 2:3 tech. 2nd shift 2:30 1 med tech. 3rd shift and 1 med tech". On 8/24/2021 at apfacility tour with the members were obs	pm - 2 RA's and 1 med pm to 10:30 pm - 2 RA's and ft 10:30 pm to 6:30 am 1 RA proximately 10:45 AM during a facility owner, two staff erved on the SCU. One of the g the hall while the other was			36	

Division of	Licensing and Protect	tion	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SUF	RVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	20
AND PLAN OF	CORRECTION	IDENTI IDANION NO.	A. BOILDING.		C	
	*		D MINO		08/30	2021
		0657	B. WING			
		STREET ADD	DRESS, CITY, STAT	E, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER		OT STREET			- 1
BROMLEY	MANOR	MANCHES	STER CENTER,	VT 05255		
				CIDOWIDER'S PLAN OF CORRECTIO	ON	(X5) COMPLETE
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	3 BE	DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	2,11,27,2	
ING	Processor and a contract of the contract of th					
	A 11 1 P	- 2	R132		501	1
R132	Continued From pag	je Z		As reported to surveyor, the	e RN	1
	8	-	6	added dates to assessmen		1
	Per interview with a	RA/Med Tech on 8/14/2021	()	reflect that they had been o		1
	at approximately 11	:30 AM there are currently 9	1	but were not accessible. T		
	residents who live of	n the SCU, and there are		date added was 8/24/2021		
	often only two RAs	assigned to the unit on day		the assessments in question		
	shift and evening st	nifts. RA responsibilities	1	were completed and put in		1
	include, serving bre	akfast on the unit and		residents' charts on 8/31/2		
	assisting dietary sta	aff with lunch and supper. RA on the floor and a Med		All further Assessments wi		1
	Tack who passes n	nedications and assists the RA		done by hand or will be pri		
	with care when all	e. There are no housekeeping		from the computer at time	OI	December
	staff and the RAs	are assigned cleaning by a		completion and added to resident's charts. RN will		31,2021
	cleaning schedule.			complete all assessments	in a	
					III a	1 1
	Per phone intervie	w with the facility Administrator	1	timely manner.		1
1	on 8/30/2021 at 2:	15 PM there are currently 9	1	Monthly audits for 3 month	s then	1
	residents on the S	CU currently. S/he confirmed	1	quarterly.	3, 111011	1
	that there are ofter	2 RAs on the SCU or 2 RAs	1	quarterry.		1
	on each side with	one who helps on both units.	4	N .		- 1
N			R136			1
R13	6 V. RESIDENT CA	RE AND HOME SERVICES	17,00			
SS=	E	i i	1			
1	5.7. Assessment		y			1
	5.7. Assessment		-			
	5.7 c. Fach reside	ent shall also bé reassessed	1			
1	annually and at a	ny point in which there is a	1	1		
1	change in the res	ident's physical or mental		4		
	condition.		1			
			1			1
1			1	V		
	- DECLUSE:	ENT is not mot as evidenced	T.	1		
	1	ENT is not met as evidenced	- 6			
	by:	terview and record review the				1
1	Based on stall in	e (RN) failed to conduct an				
	annual Resident	Assessment for 3 of 4 residents				
	in the sample (R	esidents #1, #3, and #4). In	1 "			

Division o	of Licensing and Protect	tion			and the second	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLI	
		0657	B. WING		08/3) 10/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	re, zip code	H	
BROMLEY	MANOR		OT STREET	NOT DECEM		
		MANCHE	STER CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. L'SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
R136	Continued From pag	e 3	R136			
	assessments, after the surveyor, that are no standards of practice	nade late entry notes on the ney were requested by the tin line with professional regarding dating/timing of competed. Findings include:				
	the facility on 1/16/20 Resident Assessmen	s no evidence in the record nt Assessment being			3	
	most recent Resider completed on 7/16/2	020. There was no evidence nt Assessment being				
12	most recent Resider completed on 4/8/20	20. There was no evidence nt Assessment being	-	20	N.	
	asked to provide the Assessments for Re RA/Med Tech return had been previously with the following in initial review:	with a RA/Med Tech s/he was a most recent Resident sidents #1, #3, and #4. The led with the assessments that a reviewed by this surveyor formation added since the lent Assessment now stated,				
	"Reviewed- No Cha initials). Resident #3's Resid "Reviewed, updated (with RN's initials).	dent Assessment now stated, with no changes 7/14/2021			is .	

5BDO11

	Licensing and Protect	etion	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURV	EY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING:		COMPLETE	
AND PLAN OF	CORRECTION	102.00	A. BOILDING.		С	1
		į.	B. WING		08/30/2	021
		0657	B. WING			
	and the second s	STREET AL	DRESS, CITY, STATE	E, ZIP CODE		1
NAME OF PR	OVIDER OR SUPPLIER		OT STREET			3
BROMLEY	MANOR	MANCHE	STER CENTER,	VT 05255		
			ID I	DOCUMER'S PLAN OF CORRECTION	N	(X5) COMPLETE
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	Dia.	DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		
ino	P.			-3162		
D.100	0 11 15	22.4	R136	1a. Bromley manor has re-	written	
R136	Continued From pag	je 4	In sweet.	the orientation program to it	nclude;	1
			1 1	Resident Rights,	1	1
1	During an interview	on 8/24/2021 at	4 1	Abuse/Neglect/Exploitation,	, HIPPA,	1
	approximately 4:15	PM the RN confirmed that the		Communication with Elders		1
	handwritten entries	on each resident assessment	1	Observing Professional Bou		4
	had been added on	8/24/2021, not when they	- 1	Bloodborne Pathogens,		- 1
1	were due. The RN	also confirmed that there was		Handwashing, Safe Linen H	landling,	
1	no evidence that the	e annual Resident		Covid 19, Back Safety,	0.	Ť.
1	Assessments had t	been completed for Residents		Fire/Evacuation, Emergence	v	1
1	#1, #3, and #4. S/h	e believes the assessments	Į.	Response, Alzheimer's Car		
1	had been complete	d when they were due but is	1	and Preventing Pressure U		1
	unable to locate or	retrieve them.	1	New Employees will comple		1
1	I SECTION IN THE SECTION OF SECTI	and the desired Teeth on		the five training days and a		
1	During interview w	ith the RA/Med Tech on		employees will complete ar		
	8/24/2021 at appro	oximately 5:50 PM s/he he time that s/he went to		All Current Employees will	complete	March
1	confirmed that at ti	ecent assessments the RN	+	the new Orientation Progra	m within 3	31,
1	retrieve the most re	ach assessment that they had	1	months with a date of comp	aletion of	2022
4	documented on ea	the dates they were due.		March 31, 2022.	7000011 01	
	been reviewed on	the dates they word dask		IVIAICII 51, 2022.		
6207031		DE AND HOME SERVICES	R179	1b. An Education Binder w	/as	1
		RE AND HOME SERVICES		created to show education		
SS=8		,	1	monthly as well as individu	al training	October
1	E 44 Ct-# Consiso			files on each employee was		31, 2021
1	5.11 Staff Service	5	1		3 Created	
	5 11 b. The home	must ensure that staff		by October 31,2021		
1	demonstrate com	petency in the skills and	\.	1c. Alzheimer specific trair	aina will	la la
	techniques they a	ire expected to perform before				
1	providing any dire	ect care to residents. There	1	be provided on going and e		
1	shall be at least to	welve (12) hours of training each		employee working on the N		
1	vear for each stat	ff person providing direct care to		Care Unit will complete the		ř.
	residents. The tr	aining must include, but is not		of Dementia Training. Curi		
-	limited to, the foll	owing:		Employee will complete wit		1
				months with a completion of		March
	(1) Resident righ	nts;	1	March 31, 2022 and annua	illy. New	31,
	(2) Fire safety a	nd emergency evacuation;	1	employees will complete th		2022
	(3) Resident em	ergency response procedures,		of training with 3 months of	r nire.	1
	such as the Hein	nlich maneuver, accidents, police	4			1
	or ambulance co	entact and first aid;		Auditing will be done month	nly for 3	
1	(4) Policies and	procedures regarding mandatory	T.	months then quarterly.		

Division of	f Licensing and Protect				(X3) DATE S	NIBNEY]
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMPL	
		0657.	B. WING			30/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	ZIP CODE		580
BROMLEY	MANOR		OT STREET STER CENTER, V	Т 05255	()	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
R179	Continued From pag	e 5 glect and exploitation; affective interaction with	R179	9		
	residents; (6) Infection control limited to, handwash maintaining clean er pathogens and universidents.	measures, including but not ing, handling of linens, ivironments, blood borne ersal precautions; and sion and care of residents.			8°	
	by: Based on staff inter	T is not met as evidenced view and record review the de required training and for staff delegated to provide			v	×
	documented trainin hours of dementia second training on evidence of any other the required; reside emergency evacua response procedures maneuver, accident contact and first aid regarding mandato and exploitation.	I's education records the only g present for 2020-2021 is 9 specific training in 2020 and a 6/13/2020. There was no ser training provided including ent rights, fire safety and tion, resident emergency es, such as the Heimlich ts, policies, or ambulance d, policies, and procedures ry reports of abuse, neglect espectful and effective idents, general supervision, ats.	1'			
	following education 7/12/2020 Med tra COVID, 8/5/2020 I 8/5/2020 Understa Standard precaution	2's education records the had been provided; on ining exam, 7/1/2020 VOSHA nandwashing, 8/5/2020 PPE, anding Coronavirus, 8/5/2020 pns. There is no evidence that any in the required topics of				

TATEMENT O	Licensing and Protect F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	ETED
AND FLAN OF CONNECTION		A. BUILDING:	4	30/2021		
		0657		ZID CODE		
IAME OF PRO	OVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
	26	2595 DEI	POT STREET	- AFRE		
ROMLEY	MANOR	MANCHE	STER CENTER, V	PROVIDER'S PLAN OF CORR	ECTION	(X5)
(X4) ID PREFIX TAG	WARL DECICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL. R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	DATE
R179	Continued From page	ge 6	R179			
		safety and emergency	1.			
	evacuation residen	it emergency response				
	procedures such a	s the Heimlich maneuver,	1 1			
	accidents, police, o	r ambulance contact and first	1			
	aid, policies, and p	rocedures regarding	1 1			
	mandatory reports	of abuse, neglect, and	1 1			1
	exploitation; respe-	ctful and effective interaction				1
	with residents, and	general supervision and care				
	of residents.					
	Per review of RA#	/3's education records s/he				
	received Med Tecl	training 6/16/2020. However,				1
	there is no eviden	ce of any of the required	1			- 1
	training in her/his	file.				1
	and the second second second second	#4's education record the only .				4
	Per review of KA	in 2020 and 2021 was COVID				
	training provided	020. There is no evidence of				V
	any of the require	ed training in her/his file.				1
	Control of the Contro					
	Per interview with	2 RA/Med Techs on 8/24/2021,		1		
	at approximately	11:30 AM there has been no		1		1
		provided to staff this year of				A.
U.	2021.		1	1		4
	Day intendent with	h a RA/Med Tech on 8/24/2021	1			100
	of 5:50 PM s/he	has recently taken on the	1	-		
	responsibly of fil	ing and tracking staff training.				1
	There had not be	een an organized filing system	1			1
	and it is "a work	in progress". During the interview		1		1
	the Med Tech ha	ad several piles and folders of	1	1		1
1	lose training dod	cuments however, s/he was	A	1		
	unable to locate	training for the 4 RAs reviewed.				
R: SS	302 IX. PHYSICAL F	PLANT	R302			
	0.44 51	and Emergency Preparedness	V			
1	9.11 Disaster a	and Emergency Prepareditiess	- ×:			1

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Division of Licensing and Protection (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: _ C 0657 08/30/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2595 DEPOT STREET BROMLEY MANOR MANCHESTER CENTER, VT 05255 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY R302 R302 Continued From page 7 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 bullding Fire Drills will be scheduled on a when necessary. All staff shall be instructed quartely basis and a drill was periodically and kept informed of their duties completed on 10/06/2021 and a under the plan. Fire drills shall be conducted on notice was posted. Earlier this at least a quarterly basis and shall rotate times of year, our plan was discussed at a day among morning, afternoon, evening, and meeting with the residents. At night. The date and time of each drill and the that time, a copy of the names of participating staff members shall be fire/emergency plan was put in documented. the residents' mailbox. A copy will be added to the staff handbook and to our welcome packet. The fire drills will recorded in a binder This REQUIREMENT is not met as evidenced October with date, time and signatures of 6, 2021 Based on record review and staff interviews the all that attended by 10/06/2021 facility failed to conduct required fire drills in 2021. Findings include: Will be audited quarterly to ensure compliance. Per review of the fire drill logbook provided there is no evidence present that any fire drills have been conducted throughout 2021. Per interview on 8/24/2021 at 5:30 PM the facility owner s/he thought that at least one drill had been conducted in 2021 however, s/he did confirm that there was no documented evidence that required fire drills had been conducted in 2021.

STATE FORM