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

July 3, 2023

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 **May 3, 2023.** 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

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 _____	05/03/2023

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
R100	Initial Comments: An unannounced on site re-licensure survey was conducted by the Division of Licensing and Protection on 5/3/2023. There were regulatory violations identified as a result of this survey.	R100		
R132 SS=D	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 staff interview and record review the facility failed to provide staff to resident ratios that were outlined in the facility's Special Care Unit (SCU) request for approval. Findings include: Per review of the resident census there are 10 Residents residing on the SCU. The facility's SCU request for approval states "staffing will be as follows, using a 4 to 1 ratio: 1st shift, 6:30 am to 2:30 PM - 2 RA's and 1 med tech. 2nd shift 2:30 PM to 10:30 PM - 2 RA's and 1 med tech. 3rd shift 10:30 PM to 6:30 am 1 RA and 1 med tech". Review of the facility schedule for 4/21- 5/18/23 revealed that there were 2 staff members assigned to the SCU on day shift and evening shift, a 5 to 1 ratio. There was one staff member assigned to the SCU on night shift, a 1 to 10 ratio.	R132	Staffing guidelines on SCU will be initiated to provide a 4 to 1 ratio per SCU requirements. Schedules will be monitored by staffing coordinator and management to ensure proper ratios are met. Bromley Manor will pursue an amendment to the staffing staffing statement by September 30, 2023. Tag R132 accepted on 6/30/2023 - S. Freeman/C. Scott Mary Norma 6/30/22	June 30, 2023 September 30, 2023

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R132	Continued From page 1 Per interview with the facility manager on 5/3/2023 at 2:30 PM there were currently 10 residents residing on the SCU. S/he confirmed that there were 2 staff assigned to the SCU on days and evenings making a 5 to 1 ratio and 1 staff member assigned to the SCU on nights making a 10 to 1 ratio.	R132		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that symptoms signs of illness or accident are recorded at the time of occurrence, along with actions taken. Findings include: Per record review it was noted on 4/8/22 at 9:41 AM that "Resident has a bruise on right upper breast and is complaining of left shoulder pain from yesterday's fall". On further review of resident #1's chart there is no documentation of an accident occurring on 4/7/22. Per interview with Med Tech on 5/3/23 at approximately 3:00 PM s/he confirmed resident #1 was found on the floor in her/his room on the morning of 4/7/22. Resident #1 stated that s/he had slipped out of her wheelchair. Resident #1 was asked if s/he would like to go to the hospital	R150	Bromley Manor will review and update Policies and Procedures on all services provided at facility, to include incident reporting. These Policies and Procedure will be kept in a binder in the nurses station. Staff will be educated on policies and procedures, incident reporting and the location of the policies and procedure binder. Tag R150 accepted on 6/30/2023 - S. Freeman/C. Scott	September 30, 2023 September 30, 2023

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R150	Continued From page 2 and s/he stated no, I just want you to help me up. Med Tech then stated, "I asked the nurse what to do and was told to grab assistance to help resident #1 up, at that point myself and three other employees helped resident #1 off the floor by having two employees lift under (resident #1's) arms and one at (resident #1's) feet". S/he then stated, "I asked if I should put a note in (resident #1's) cart and was told no, don't worry about it". Per interview with facility nurse on 5/3/23 at 3:20 PM s/he stated s/he was in the facility at the time of incident and was aware resident #1 had been found on the floor in his/her room. S/he stated "Resident#1 denied medical treatment at time of incident". S/he further stated that "(Resident #1) has admission diagnosis of a torn rotator cuff, and chronic osteoarthritis". When asked if s/he had documentation of an assessment, or incident report s/he stated, "If it is not in the cart, I don't have it".	R150		
R160 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of	R160	Bromley Manor will review and update Policies and Procedures on all services provided at facility, to include medication management and expired medication disposal These Policies and Procedure will be kept in a binder in the nurses station. Staff will be educated on policies and procedures including medication disposal and the location of the policies and procedure binder. Tag R160 accepted on 6/30/2023 - S. Freeman/C. Scott	September 30, 2023 September 30, 2023

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R160	Continued From page 3	R160		

the home's policy prior to admission.
(2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home.
(3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff.
(4) How medications shall be obtained for residents including choices of pharmacies.
(5) Procedures for documentation of medication administration.
(6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.
(7) Procedures for monitoring side effects of psychoactive medications.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, there was a failure of the RCH to develop a written policy and procedure describing disposing of outdated or unused medication, including designation of person or persons with responsibility for disposal. Findings include:

Per observation of the facility medication cart located in Special Care Unit, it was noted that expired medication, and creams, were observed to be in use. Findings include 56.7g surgical lubricant expired 12/2022, 18oz tub of hemorrhoidal cream expired 11/22, 28ml sure-prep barrier film expired 2/22, and 100 count chewable antacid tablets expired 4/13.

Per interview with facility RN on the afternoon of 5/3/23 when asked what the facilities policy was

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R160	Continued From page 4 regarding disposing of outdated medications s/he stated, "We all go through the carts regularly, but I am unaware of a written policy". This was confirmed by the owner of the facility on the afternoon of 5/3/23 at approximately 2:00 PM.	R160		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse (RN) failed to ensure a written plan for the use of as needed (PRN) medication was developed. Findings include: Per record review Resident #2 has an order for Clonazepam 0.5mg, to take 1-2 tabletes twice daily as needed. The record does not include a	R167	All orders will be reviewed by facility RN to ensure they are correctly written to include an appropriate indication of use, dosing and established time frequency. RN is to work with physician and pharmacy to correct any orders immediately that are not meeting these standards. All orders will be reviewed prior to administration of the medication. The order for Resident #2 has been clarified with the physician on 06/01/2023. Tag R167 accepted on 6/30/2023 - S. Freeman/C. Scott	June 30, 2023

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R167	Continued From page 5 plan to describe the specific behaviors the medication is intended to correct and follow up monitoring to determine if the medication is effective with desired outcomes or with undesired effects. The order as written does not specify an appropriate indication of use, the order includes a range in dose and does not establish the time freqency of administrations. During interview with the RN on 5/3/23 at 1:00 PM, s/he confirmed a behavioral plan has not been developed for the use of the Clonazepam and the medication order is incomplete. The RN acknowledged the order does not contain indications of use, a specific dose, and appropriate frequency.	R167		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with	R179	Bromley Manor has a Orientation Program that was implemented in 2022 that includes:Resident RIghts, Abuse/Neglect/ Exploitation, HIPPA, Communication with Elders, Observing Professional Boundaries, Blood-borne Pathogens, Hand Washing, Safe Linen handling, Covid 19, Back Safety, Fire/ Evacuation, Emergency Response, Alzheimer's Caregiving and Preventing Pressure Ulcers.This program will be completed upon hire prior to training on the units and all current employees will repeat this training annually. All education will be kept in the Education Binder under the Month and Year completed. Individual training files on each employee will be kept up to date. Alzheimer specific training will be provided on going and each employee working on the MemoryCare Unit will complete 10 hours of Dementia Training. New employees will complete will complete within 3 months of hire.	June30, 2023 June 30, 2023 June 30, 2023

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R179	Continued From page 6 residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure 1 out of 5 sampled staff completed all required yearly training. Findings include: Per review of the employee training records provided one caregiver did not complete all the required yearly training to include: resident rights, fire safety and emergency evacuation, resident emergency response procedures, such as the Heimlich maneuver, accidents, police, or ambulance contact and first aid, policies, and procedures regarding mandatory reports of abuse, neglect and exploitation, respectful and effective interaction with residents, general supervision, and care of residents. During interview at 3:30 PM on 5/3/23 the owner confirmed s/he was unable to provide documented evidence of completion of all required yearly training for 1 out of 5 sampled staff.	R179	Tag R179 accepted on 6/30/2023 - S. Freeman/C. Scott	
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures	R200	Bromley Manor will review and update Policies and Procedures on all services provided at facility, to include incident reporting. These Policies and Procedure will be kept in a binder in the nurses station.	September 30, 2023

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R200	Continued From page 7 Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview there was a failure to maintain written policies and procedures related to Resident falls and what to do in the event of a fall. Findings include: Per interview on 5/3/23 at 9:42 AM Resident #1 stated that s/he had sustained a fall in her/his room on 4/7/22 in which s/he needed assistance from staff to get off the floor. S/he further stated that the staff seemed to be confused on how to assist her/him off the floor. Resident #1 expressed concern that the staff seemed to be uneducated on how to assist someone after a fall or injury. Per review of written policies and procedures provided it was noted there was no written policy and procedure for falls. A Medical Emergency policy lists falls as an emergency however, this policy does not indicated what actions staff should take in the event of a fall. During interview on 5/3/23 at 3:20 PM the facility manager and nurse confirmed the facility did not have a policy and procedure related to Resident falls and actions that staff should take in the event of a Resident fall.	R200	Staff will be educated on policies and procedures, incident reporting and the location of the policies and procedure binder. Tag R200 accepted on 6/30/2023 - S. Freeman/C. Scott	September 30, 2023
R247 SS=F	VII. NUTRITION AND FOOD SERVICES	R247		

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R247	Continued From page 8 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews there was a failure to ensure all perishable food and drinks were labeled and dated. Findings include: During a tour of the facility kitchen and food service area commencing at 09:07 AM on 5/3/23 the following perishable food items were observed to be improperly stored: In the reach- in refrigerator, multiple items were not labeled as to when they were opened. These items include a half gallon of milk, 2 pitchers of iced tea, and 6 1-gallon containers of salad dressing. In the walk-in refrigerator 4 5 lb bags of cheese, 46 oz jar of apple sauce, half gallon of milk, 15 oz container of mayonnaise, 5 lb container of sour cream, 32 oz of ricotta cheese, 1 qt of heavy cream, 8 lb container of salsa, 1-gallon of Worcestershire sauce, and 3 1-gallon Ziploc bags of chicken were noted to be open and undated. In the dry storage area, 4 bags of raisin bran cereal, 4 bags of corn flakes, and 4 bags of brownie mix were noted to be stored out of original packaging and without expiration dates. These findings were confirmed by the food service manager during the facility kitchen tour.	R247	Bromley Manor will educate all kitchen staff on rrequirements of labeling/storage all food and beverage items. Bromley Manor with ensure kitchen staff checks the food and beverages in the kitchen daily to ensure that all food items are labeled and stored appropriately. There will be a daily log kept to ensure compliance. The logs will be reviewed by management weekly to ensure compliance. There will be posted instructions in the kitchen on proper labeling and storage of foods and beverages. Tag R247 accepted on 6/30/2023 - S. Freeman/C. Scott	June 30, 2023 June 30, 2023 June 30, 2023
R251 SS=F	VII. NUTRITION AND FOOD SERVICES	R251		

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R251	Continued From page 9 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 staff interview, the facility failed to ensure food and drinks were stored in a manner as to protect them from dust, insects, rodents, and overhead leakage. Findings include: During the tour of facility kitchen and food storage areas commencing at 9:07 AM on 5/3/23 the following observations were made. In the walk-in refrigerator 2 prepackaged hams were noted to be stored above an open box of bread, and 3 1-gallon Ziploc bags containing raw thawed chicken were noted to be stored in a crate located on the floor. In the walk-in freezer Boxes of Broccoli, Butternut squash, Diced Carrots were stored on the floor under the shelving unit. (2) 1-gallon containers of Frozen tomato sauce were observed uncovered. During interview on 5/3/2023 at 9:07 AM the food service manager confirmed that the observed items were not properly stored to protect from sources of contamination.	R251	Bromley Manor will educate all kitchen staff on rrequirements of labeling/storage all food and beverage items. Bromley Manor with ensure kitchen staff checks the food and beverages in the kitchen daily to ensure that all food items are labeled and stored appropriately. There will be a daily log kept to ensure compliance. The logs will be reviewed by management weekly to ensure compliance. There will be posted instructions in the kitchen on proper labeling and storage of foods and beverages. Tag R251 accepted on 6/30/2023 - S. Freeman/C. Scott	June 30, 2023 June 30, 2023 June 30, 2023
R266 SS=D	IX. PHYSICAL PLANT	R266		

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R266	Continued From page 10 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a safe environment. Findings include: 1. During the environmental tour of the activity a large flat screen television was observed to be balanced on 2 chairs and not secured to the wall. An interview with the Maintenance Employee at 10:48 AM confirmed the television was not secure to a wall, s/he indicated "the television will be wall mounted, however the attachment is on order." 2. During the environmental tour of a residential hallway oxygen was observed in use by Resident #3 while occupying his/her room. The hallway of the room, entry to the room, and the interior of the room did not have proper signage posted. Per NFPA 101 Life Safety & NFPA 99 Health Care Facility Code, it is recommended signage is needed when oxygen is in use. In addition, per Lippincott Manual 8th addition Administering Oxygen by Nasal Cannula Procedure Guideline 10-14; page 244: "Performance phase 1. Post NO SMOKING signs on the patient's door and in view of the patient and visitors" . During interview on 5/3/2023 at 5:30 PM the Manager confirmed that signage was not posted, and acknowledged the use of appropriate	R266	1. The flat screen TV in the activity room has been replaced with a wall mounted TV. The facility will refrain from using unsecured TV's in the facility. 2. All residents that have oxygen ordered will have appropriate signage posted for oxygen in use and no smoking per guidelines. Tag R266 accepted on 6/30/2023 - S. Freeman/C. Scott	June 30, 2023 June 30, 2023

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R266	Continued From page 11 signage when oxygen in use to maintain a safe environment.	R266		
R285 SS=D	IX. PHYSICAL PLANT 9.4 Recreation and Dining Rooms 9.4.d Smoking shall be permitted only in designated areas and the home must ensure that residents who object to smoke have "smoke free" dining or recreation space. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the manager failed to ensure smoking was occurring in only designated areas of the facility. Findings include: During the facility tour of the memory care unit, the outdoor deck area was observed to have a medium sized galvanized pale that contained discarded cigarette butts. On 5/3/2023 at 2:30pm the facility manager identified the designated smoking areas of the community. The manager observed the pale of discarded cigarette butts and confirmed the area as a residential space and not designated for smoking.	R285	Smoking will be allowed in designated areas only effective immediately. A written notification of the designated smoking areas will be provided to both employees and residents. Management will monitor for compliance and take immediate action to rectify any inappropriate smoking on the premises. Tag R285 accepted on 6/30/2023 - S. Freeman/C. Scott	June 30, 2023
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas.	R291	Hot water temperatures were immediately adjusted to reflect 120 degrees Farenheit per state regulations. Water temperatures will be monitored weekly times 1 months and then monthly. A log of these checks will be kept in the Administrator's Office.	June 30, 2023

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 _____	05/03/2023

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
R291	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure water temperatures did not exceed 120 degrees Fahrenheit in resident areas of the residential care home (RCH). Findings include: Per observation on 5/3/23 at 5:15 PM water temperatures exceeded the recommended 120 degrees Fahrenheit in four resident rooms. Resident room #E8 water temperature was noted to be 133.2 degrees Fahrenheit, resident room #E11 water temperature was noted to be 129 degrees Fahrenheit, resident room #A10 water temperature was noted to be 121.4 degrees Fahrenheit, and resident room #A4 water temperature was noted to be 121.6 degrees Fahrenheit. This observation was confirmed by the facility manager on 5/3/23 at 5:30 PM stating " We will have this issue resolved by the end of today".	R291	Tag R291 accepted on 6/30/2023 - S. Freeman/C. Scott	
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	R302	Fire Drills will scheduled on a quarterly basis. These drills will be recorded in a with date and time and signatures of all that attended. We will continue to provide a copy of fire/ emergency plan to the staff upon orientation and annually and a copy will be provided in our resident welcome package. Management will review quarterly for compliance. Tag R302 accepted on 6/30/2023 - S. Freeman/C. Scott	September 30, 2023

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 _____	05/03/2023

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
R302	Continued From page 13 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 staff interview the facility failed to ensure that fire drills were conducted during the previous 12 months. Findings include: On 5/3/23 the facility co-owner were asked to demonstrate via documentation that they had conducted fire drills on a quarterly basis and rotating times among morning, afternoon, evening, and night. Based on record review the facility failed to provide evidence of any fire drills being conducted on a quarterly basis with rotating times over the past year. This was confirmed by the facility co-owner on 5/3/23 at 3:45 PM stating "I conduct weekly meetings with staff and residents to discuss what to do in the event of a fire." However, there had been no actual fire drills conducted.	R302		