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 24, 2024

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 **September 19, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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 _____	09/19/2024

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 onsite relicensure survey was conducted by the Division of Licensing and Protection on 9/17/24 and completed on 9/19/24. Regulatory deficiencies were identified. Findings include:	R100		
R132 SS=F	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 9/6/24-9/19/24 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	R132	Mary Norman Owner Administrator 10/18/24	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R132	Continued From page 1 assigned to the SCU on night shift, a 1 to 10 ratio. During the course of onsite, the census of the SCU changed from 10 residents to 9 residents. Per interview with the facility manager on 9/19/24 at 2:30 PM S/he confirmed that there were 2 staff assigned to the SCU on days and evenings and 1 staff member. The manager confirmed the ratios established within the SCU plan, are not met with the current staffing pattern.	R132		
R145 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to ensure the written plans of care for 3 residents of the applicable sample were updated to reflect the care and services necessary to assist the residents. 1.) Per interview on 9/18/24 at 1:30 PM, the Care Staff confirmed Resident #1 to require a wheelchair with locomotion, staff indicated the resident is able to ambulate short distances within room. Staff confirmed the resident to require support with locomotion.	R145		

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R145	Continued From page 2 Per record review Resident #1 care plan was last updated on 8/5/24, the plan of care does not indicate the use of a wheelchair for locomotion, or staff assistance with locomotion. 2.) Per interview on 9/18/24 at 1:30 PM, the Care staff confirmed Resident #5 to ambulate short distances, and utilizes a wheelchair at all other times. Per record review Resident #5 plan of care, does not indicate the resident to utilize a wheelchair. 3.) Per staff interview on 9/18/24 at 1:45 PM Resident # 7 requires a hoyer for all transfers out of bed, staff confirmed resident is care planned for bed bound care with two assist. Per record review, the plan of care for Resident #7 does not include the use of a hoyer for transfers. Per interview on 9/18/24 at 2:30 PM . the RN confirmed the plan of cares for Resident #1, #5, and #7 to not have been updated with the identified areas of mobility, transfer and locomotion assistance required by staff.	R145		
R147 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;	R147		

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R147	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure all medication orders included specific dose and frequency of administration. Findings include: Per record review of Medication Administration records and resident physician orders, the record revealed orders contained dosages with a range for administartion, a frequencys with a range of time to be administered. a.) Resident #3 has an order for Morphine 0.25mL syringes with a range dose of 0.5 mL up to 1 mL to be administered every 2 hours as needed and an order for Lorazaepam 0.5 mg tablet, to adminsiter 1-2 tabs every two hours as needed. b.) Resident #4 has an order for Ibuprophen take 2 tablets by mouth every 6 to 8 hours as needed for pain/fever. Per interview on 9/18/24 at 3:00 PM the Registered Nurse confirmed the orders included range dosages and frequency to administer for Resident's # 3 and #4.	R147		
R161 SS=F	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	R161		

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R161	Continued From page 4 designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on record review and staff interivew, the Manager failed to ensure medications were handled according to the home's policy and procedures. Per staff interivew on 9/19/24 at 12:30 PM, staff confirmed medications are administered by Medication Tech trained by the Registered Nurse. The staff acknowledged through the interview, that the medications are to be passed to residents per the schedule times in the Medication Administration Record (MAR) within in a one hour window prior to the schedule time and/or 1 hour following the scheduled time. Per record review, a facility policy titled Assisting with Routine Medications states "There is usually a window of time, typically one hour on either side of the assistance time noted on th medicatin record, during which is accpetable to give the medications" During the course of the on site visit, staff were observed to be preparing and administering medications, after 9:30 AM. A medication audit report was produced and provided to the surveyor of medications administered greater than 1 hour after the scheduled time from June 19,2024 - Septemeber 19, 2024. In review of the medication audit report, as of September 1, 2024 to September 19, 2024, 14 residents received medications approximately 90 minutes after the scheduled administration per the MAR.	R161		

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R161	Continued From page 5 In an interview on 9/19/24 at 2:00 PM, the Manager confirmed the policy for Assisting with Routine Medications, and indicated the morning shift begins at 6:30 AM and staff begin to administer medications, once shift hand off is completed. The Mananger acknowledges to be unaware of a process established in monitoring medication administration to ensure the established policy is followed with administering in a the indicated timeframe.	R161		
R171 SS=F	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 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.	R171		

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R171	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to ensure medications were administered per physician orders. Per record review, Resident #3 order for Lorazepam, indicated to administer every two hours as needed. The medication administration recorded was documented to have Lorazepam administered on 9/17/24 at 8:38 AM and 9/17/24 at 9:23 AM. Per interview on 9/18/24 at 12:30 PM the Medicaticon Tech confirmed the medications documentation as administered. Per interview on 9/18/24 at 3:00 PM the Registered Nurse confirmed the medication order and acknowledged the medication was given less than two hours apart on 9/17/24.	R171		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to complete National Background Checks as required by the licensing agency for all newly hired staff.	R190		

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R190	Continued From page 7 Per record review of staffing records, 2 out of 5 staff national criminal background checks were not completed by the facility. Per interview on 9/18/24, Lead Staff Member, confirmed the records do no include national criminal background checks. Per interview on 9/19/24 at 12:30 PM, the Manager confirmed national criminal background checks were not completed on newly hired staff. The manager confirmed the policy had not been updated with the requiremnet.	R190		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures 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 staff interview the RCH failed to ensure policies and procedures were established to govern services provided by the home. Per review of the Facility Policy and procedures, the following Policy and Procedures were not established or updated to reflect current regulatory guidance provided by the licensing agency. 1.) The policy and procedures for Criminal Background Checks was not updated to include guidance provided by the licensing agency on	R200		

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R200	Continued From page 8 5/1/23 to include National Background checks and annual re-checks of applicable criminal background and Abuse registry checks. 2.) A policy and procedure on the management of mobility bars utilized by residents within the home. Per interview with on 9/19/24 at 12:30 PM, the Manager confirmed Policy and Procedures were note updated for Background Checks and policy for the use of mobility bars is not established.	R200		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 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 interview, the RCH failed to ensure all perishable food and drink were labeled, dated and held a proper temperatures. Per observation of the facility Kitchen commencing at 9:00 AM the dry storage pantry was observed to have 3 large storage containers containing flour and sugar(s) without a label to identify the item, dates they were repackaged into the container and the date to use by. Multiple items were observed to not have the use by date/date of expiration available on the item	R247		

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R247	Continued From page 9 packaging, these items include, Pancake mixes, Waffle Mix, Packages of pudding. During a tour of the Kitchen and Dining Services areas of the facility commencing at 9:00 AM on 9/17/24 the drink dispenser in the kitchen observed to store and serve perishable beverages above 40 degrees Fahrenheit including: a. Cranberry Juice 48.0 degrees Fahrenheit b. Apple Juice 48.3 degrees Fahrenheit c. Orange Juice 54.1 degrees Fahrenheit Per interview on 9/17/24 at 9:25 AM, the Chef confirmed the items did not include proper labeling and the juices temperatures. Per interview on 9/19/24 at 10:15 AM, the Owner confirmed the RCH to have policies and procedures to established for proper labeling of goods, storage practices of food items, and maintaining proper temperatures of perishable foods.	R247		
R250 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.e The use of outdated, unlabeled or damaged canned goods is prohibited and such goods shall not be maintained on the premises. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the RCH failed to ensure food items foods stored within the pantry, were within appropriate expiration and out of date items were	R250		

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R250	Continued From page 10 not stored and available for use. Per observation on 9/17/24 at 9:10 AM multiple items were found to be stored with in the dry storage pantry exceeding the identified expiration date. These items include, cake mixes, corn tortilla, and containers of Jetpuff Marshmellow. Per interview on 9/18/24 at 9:20 AM the Chef confirmed the items identfiied were stored passed the expiration dates indicated.	R250		
R266 SS=F	IX. PHYSICAL PLANT 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 RCH failed to provide a safe care environment within residential areas. 1. Per observation on 9/18/24 of the Special Care unit, cleaning/sanitizing chemical were observed on a shelf accessible to residents. Additionally, in the kitchenette, a bucket was stored on the floor, contained sanitizer and additional cleaning chemicals, the door to the kitchenette was observed to remain ajar through follow up observations on 9/18/24. The facility policy titled Housekeeping and Laundry Services indicates "Keep all chemicals	R266		

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R266	Continued From page 11	R266		

and cleaning products in a protected area inaccessible to residents."

Per interview on 9/18/24, the staff of the SCU confirmed the chemicals are utilized for sanitizing and confirmed the chemicals are stored in the kitchenette in a discrete way. The staff confirmed there is not a secure location to store the chemicals in the kitchenette.

2. Per observation on 9/17/24 at 9:30 AM, multiple resident rooms were observed to have transfer bars attached to their beds. Upon inspection, Resident # 1, mobility bar was able to be lifted out of place, dislodging the bar from its framing, and exposing rough medal edges. In further inspection, the bar securement measure was in poor repair, preventing safe use with bed mobility.

Per interview on 9/18/24 at 1:40 PM, care staff confirmed to be unaware the mobility bar was in poor repair and confirmed staff have not been delegated to observe the mobility bars to ensure safe use and repair.

Per interview, on 9/18/24 at 3:00 PM the Registered Nurse confirmed to be unaware of a process to observe/monitor the mobility bars to ensure safe use and proper repair. The RN was unaware Resident #1 mobility bar was in poor repair and not secured.

3. Per observation on 9/18/24, medications were observed to be stored in Resident # 2 room, unsecured in a cabinet, the medication include, a bottle of Tylenol PM, Advil and Tums.

The facility policy indicated for Self-Administration identifies residents who self administer

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R266	Continued From page 12 medications are to have the medications secured in the room. Per interview on 9/18/24 at 2:00 PM the Med Tech confirmed Resident #1 does not have an order to self-administer medications and all medications stored within rooms are to be secure.	R266		
R999 SS=F	MISCELLANEOUS 4.7 A home shall not provide care to more residents than the capacity for which it is licensed. Requests for a change in licensed capacity shall be made in writing to the licensing agency. A proper staffing pattern to cover an increase in capacity shall be submitted when requested. This REQUIREMENT is NOT MET by: Based on observation, record review and staff interview, the RCH failed to ensure care was provided within the capacity of the facility licensure. The Residential Care Home current licensure expiring 12/24/24, is licensed for an occupancy 33 residents, to include 11 special care unit beds. Per interview on 9/19/24 at 10:00 AM, the Manager confirmed the license capacity has been unchanged since the facility initial licensure in 2018. The manager explained the facility has expanded with independent wings, Dogwood and as of Fall 2023, Cottonwood. The Manager acknowledged the independent agreements, are of a different format than the residential care	R999		

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R999	Continued From page 13 home agreements, which allow residents to select services the residential care facility provides, within the options of services, Medical Management is provided. The manager explained this includes residential care facility staff providing the independent care resident support with medications. The manager confirmed 13 residents reside within the independent wings, 8 out of the 13 receive medication management support from staff, and 2 out of 13 receive care assist/support/oversight from staff. The Manager confirmed the facility has a total census of 41 resident of which 35 residents receive care and services to include medical management. The Manager confirmed to not have requested a change in the facility license capacity from the licensing agency.	R999		

Deficiency Statement Plan of Correction (POC)

Survey Date: 9/19/2024

Facility Name: Bromley Manor

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R132/5.6c R 132 Accepted Jenielle Shea, RN 10/24/24	Staffing has been increased to meet the licensure guidelines to ensure the proper staff to resident ratio on all shifts. Bromley Manor will followup on its request of 6/2023 for an amendment to their license to adjust the current ratio	9/22/2024	Scheduler has been advised of the change and has incorporated the correct ratio into staff schedules	Scheduler with oversight of administrator.
R145/5.9.c (2) R 145 Accepted Jenielle Shea, RN 10/24/24	An internal audit of all care plans was completed and all care plans were updated to reflect residents current medical, mobility, transfer and locomotion assistance	10/1/2024	Audits of care plan will be made monthly.	RN and administrator
R147ss=f/5.9c(4) R 147 Accepted Jenielle Shea, RN 10/24/24	All medication records were reviewed by Nursing Director. All records/medications were updated with exact times of administration with no discretionary ranges in place.	10/23/2024	All orders will be audited on a monthly basis and updated any time new orders are made.	RN and administrator
R161/5.10b R 161 Accepted Jenielle Shea, RN 10/24/24	All Medication Techs have received additional training by the Nursing Director to ensure the established policy for medication administration is followed. Additional QuickMar training for proper documentation & annotations of med times and extenuating circumstances was provided by RN and senior Med tech staff.	10/10/2024	Additional Quick Mar training will be provided during the monthly in-service meetings. A weekly review of discretions and staff identification will be conducted.	RN and administrator
R171/5.10g R 171 Accepted Jenielle Shea, RN 10/24/24	All residents PRN medications were reviewed with the physician(S) and were updated with precise timeframes for medication administration.	10/8/2024	Medical record audits wil be completed monthly.	RN and administrator
R190 & R200 (1) R 190/ R200 Accepted Jenielle Shea, RN 10/24/24	National and annual background checks. YCCRIS was contacted to obtain information on procedure to obtain checks and obtain requirements necessary to submit to State of Vermont.	10/17/2024	Manager will update policies to include mandate and followup on procedures necessary to institute.	Administrator
R200 (2) R 200 Accepted Jenielle Shea, RN 10/24/24	Policy for the use and review of mobility bars was established and all mobility equipment was and will be inspected by maintenance staff to ensure safety conditions	10/17/2024	Inspection by care staff and maintenance staff to ensure equipment integrity.	Administrator, RN and all care staff.
R247 7.2b R 247 Accepted Jenielle Shea, RN 10/24/24	Bromley Manor has worked with kitchen staff and reviewed items improperly dated and stored. Items not dated were destroyed. The beverage machine not maintaining proper temperatures was serviced and corrected by the provider.	10/08/2024	Kitchen staff will review “safe handling” guidelines. Staff will be educated of labeling/storage of all food requirements	Chef and Administrator

R250 7.2 (e) R 250 Accepted Jenielle Shea, RN 10/24/24	Bromley Manor has worked with kitchen staff and reviewed items improperly dated and stored. Items not dated were destroyed. The beverage machine not maintaining proper temperatures was serviced and corrected by the provider.	10/08/2024	Food items will be reviewed weekly to ensure compliance	Chef and administrator
R266 9.1.a	Special Care unit was inspected and all chemicals kept in the kitchen were removed from the SCU entirely.	9/20/2024	Monitoring will continue on a daily basis.	Administrator, RN and all staff
R266 (2)	Mobility bar was inspected and adjusted for proper securement and safety	9/22/2024	Staff will be instructed to monitor bars and operation on daily basis	Administrator, RN and all staff
R266 (3) R 266 (9.1a, 2, 3) Accepted Jenielle Shea, RN 10/24/24	Unsecured medications in resident room was addressed with the resident and [redacted] self-employed care staff as to the facility's policy regarding unsecured OTC meds. Resident willing relinquished rather than securing said medications and [redacted] support staff committed to not purchasing such meds without notifying facility and securing same.	9/22/2024	Policy has been reviewed with RN and staff. Lock boxes are available for any resident if needed.	Administrator, RN and all staff.
R999 SS=F R 999 Accepted Jenielle Shea, RN 10/24/24	Bromley Manor has segregated the "independent" wings from the licensed portion of Bromley Manor. All services excepting activities and dining, are not performed by Bromley paid staff. As of 10/1/24, 11 units are rented in the unlicensed wings, 10 of which had current occupants. Nine of the SCU are under contract with eight current occupants. Residential population consists of 17 occupied units. Total units occupied is 35.	9/22/2024	Bromley Manor will correct its current licensing deficiencies by extending the number allowed or by obtaining a "floating" license. The pilot program instituted by DAIL is innovative, realistic, and exciting.	Administrator

Pronouns removed by DLP 10/24/24