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

June 6, 2018

Ms. Cindy Jerome, Manager
The Bradley House
65 Harris Avenue
Brattleboro, VT 05301-2948

Dear Ms. Jerome:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 24, 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

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0047	A. BUILDING: _____ B. WING _____	C 04/24/2018

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THE BRADLEY HOUSE	65 HARRIS AVENUE BRATTLEBORO, VT 05301

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R100	Initial Comments: An unannounced on-site re-licensing survey and two anonymous complaint investigations were conducted by the Division of Licensing and Protection on 4/23 and 4/24/18. The findings include the following:	R100	Please see attached plan of correction.	
R101 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility failed to safely and appropriately provide care needs, for 2 out of 6 sampled residents (Resident #2 and #3). The findings include the following: 1. Per medical record review, Resident #2 was admitted in January 2017. A level of care (LOC) variance was granted in September 2017 and continued through the following reporting quarter (December 2017). The resident was hospitalized in January 2018 for two over nights, for treatment of pneumonia. H/She had left the facility without supervision in January/February and March 2018. After the March elopement, the resident was hospitalized for treatment and observation of hypothermia. The facility conducted a significant change assessment in February 2018 and the resident began receiving Hospice services in	R101		

R101 - R266 POC's accepted 6/4/18 MBertrandRN/ANE

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R101	Continued From page 1 January 2018. There is no evidence that the licensing agency was notified of the condition change, the need to monitor closely for elopement and/or changes and adjustments to the resident's individual care plan. The variance identifies that the resident is eligible for a nursing home admission or has care needs that exceed that of which the Residential Care Home is licensed to provide. The facility attests that they are able to meet the needs identified in the request. The approval letter also directs the facility of the responsibility to notify the licensing agency if the resident's condition improves/declines or at the time the resident is discharged. The Registered Nurse confirm on 4/24/18 that the licensing agency was not notified about the change in Resident #2's status or that a request for an updated LOC was ever made. The Executive Director and site Director are unable to confirm or deny if a change in LOC was requested. 2. Per medical record review, Resident #3 was admitted in mid-March 2018 with diagnosis to include, but not limited to, Diabetes and Dementia. An LOC variance was requested and provided by Licensing and Protection dated 4/3/18. The resident does require daily fasting blood sugar testing and at bedtime, followed by administration if insulin injection. The resident is unable and unwilling to administer the insulin. Blood sugars are documented as low as 168 in the morning and as high as 250 at various times in the evening. The care plan identifies that the resident gets very shaky and skin becomes clammy when blood sugars are high.	R101		

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R101	Continued From page 2 Facility policy for medications identifies that ["residents who require insulin administration must be able to self-inject"]. Admission agreement signed by the site Manager on 3/22/18 identifies ["if the resident is to become insulin dependent and unable to self-inject insulin, the facility would need to give notice and find different placement for you that offers a higher level of care."] The Registered Nurse (RN) confirms on 4/24/18 at 4 PM that s/he is uncomfortable with the instability of Resident #3's blood sugars and the need to be closely monitored. The nurse also confirms that the resident refuses to administer the insulin and the medication administration record identifies staff signatures who have administered the insulin the resident daily.	R101		
R116 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.b Emergency Discharge or Transfer of Residents (1) An emergency discharge or transfer may be made with less than thirty (30) days notice under the following circumstances: i. The resident's attending physician documents in the resident's record that the discharge or transfer is an emergency measure necessary for the health and safety of the resident or other residents; or ii. A natural disaster or emergency necessitates the evacuation of residents from the home; or	R116		

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R116	Continued From page 3 iii. The resident presents an immediate threat to the health or safety of self or others. In that case, the licensee shall request permission from the licensing agency to discharge or transfer the resident immediately. Permission from the licensing agency is not necessary when the immediate threat requires intervention of the police, mental health crisis personnel, or emergency medical services personnel who render the professional judgement that discharge or transfer must occur immediately. In such cases, the licensing agency shall be notified on the next business day; or iv. When ordered or permitted by a court. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family and staff interviews, the facility failed to meet the requirements of an emergency discharge for 1 applicable resident at the time of a fall and refusing to be transferred to the Emergency Room, (Resident #4). The findings include the following: Per record review, Resident #3 was admitted to the facility in 2014. In April of 2014 the facility was provided a Level of Care (LOC) variance from the licensing agency, permitting the home to retain the resident. The variance identifies that the resident is eligible for a nursing home admission or has care needs that exceed that of which the Residential Care Home is licensed to provide. The facility attests that they are able to meet the needs identified in the request. The approval letter also directs the facility of the responsibility to notify the licensing agency if the resident's condition improves/declines or at the time the resident is discharged.	R116		

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R116	Continued From page 4 Per review of Licensing and Protection correspondence, there is no documented evidence from The Bradley House, of any formal level of care variance notification of any changes in Resident #4's health conditions. That is, until the recent fall that resulted in the Emergency Dicharge notice delivered on 3/15/18 while in the hospital. Per record review there is no evidence that the resident had been provided a 30-day discharge notice, identifying that the home could not meet the needs associated with changes in ambulation, skin integrity issues and falls. Per record review, Resident #4 experienced a fall that occurred on 3/14/18 at approximately 3:40 PM. At that time, the resident refused to go to the emergency room. However, emergency medical staff were called for assistance and transfer. The resident, family and the Registered Nurse all confirm on 4/24/18, that the resident voiced, numerous times, he/she did not need to go to the hospital. However, the resident finally conceded to Bradley House staff, who voiced that further evaluation and scanning could be completed while at the hospital. After evaluation at the hospital on 3/14/18, medical staff revealed that the resident had sustained no injures as a result of the fall and was appropriate to return the facility at that time. The Bradley House did not properly assess the resident at that time, but choose to issue an inappropriate emergency discharge notice. Resident #4 was not allowed to returen to the RCH and had to remain in the hospital without an appropriate admitting diagnosis. The resident was discharged to a long-term care	R116		

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R116	Continued From page 5 facility over an hour away from The Bradley House for approximately 30 days, and has now returned to his/her room in the facility, that s/he shares with a spouse. The return was due in part to an appeal of the discharge, which was upheld by the Division of Licensing and Protection, due to the lack of compliance with regulations governing involuntary discharges. The inappropriate Emergency Discharge added undue stress on the resident and his/her significant other; visitation was nonexistent due to transportation issues and telephone communication was the pair's only support to each other during this time. Per Residential Care Home Licensing Regulations: Involuntary Discharge and Transfer Requirement identify a 30-day discharge notice may be provided to the resident at a time when care needs exceed what the facility can provide. This notification provides the resident the right to appeal the home's decision, allowed to stay in the home during the appeal period and opportunity to locate different placement.	R116		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by the Registered Nurse (RN), the	R128		

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R128	Continued From page 6 facility failed to obtain a physician's order for the use of oxygen for 1 of 6 sampled residents, (Resident #5). The findings include the following: Per facility tour on 4/23/18, Resident #5 has as an oxygen concentrator with attached nasal cannula, two full C-Cylinder oxygen tanks and 3-4 small (2 pound) full oxygen tanks located in the resident's bathroom and hall. All tanks are free-standing and are not secured. Per review of the resident's medical record, physician orders and medication administration records identify that staff are to check nasal cannula on the oxygen concentrator weekly and change as necessary. Clean oxygen bottle twice a week in the dishwasher. There is no documented evidence by the physician for the use of the oxygen nor is there any direction as to the litter flow the oxygen is to be administered. The RN confirms on 4/24/18 at approximately 4 PM, that the order is not complete as required.	R128		
R145 SS=E	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;	R145		

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R145	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility nurse failed to ensure that 2 of 5 sampled residents had written plans of care that identify their current needs, (Resident #1 and #2). The findings include the following: 1. Per medical record review, Resident #1 has history of falls dated 7/15/17, 3/11/17 and 1/10/18. Interventions to manage falls were identified on the care plan dated 8/26/17 completed by the Registered Nurse (RN). Resident has had an annual assessment and care plan update dated 12/8/17 completed by the RN. Nurses progress notes identify falls on 4/8 and 4/17/18 that resulted in an emergency evaluation. The current care plan dated and signed by the RN on 2/7/18 does not identify falls as a concern nor are there initiatives to direct staff on the prevention any falls. RN confirms on 4/24/18 at approximately 9 AM that the care plan does not reflect the resident's current needs as it pertains to falls and the prevention of. 2. Per medical record review, Resident #2, was originally admitted to the facility in late September of 2017. During the first month of admission the resident wandered off the premises without notifying the staff. January 2018 the resident was located outside the building in the evening hours without a coat, in the cold and incontinent of both urine and feces. During the month of February 2018 (on more then one occasion), the resident was located outside of the building, was secured by staff via a vehicle, for h/she was walking downtown. Other instances of poor safety awareness by the resident are evidenced in the	R145		

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R145	Continued From page 8 nurses' notes. On Sunday 3/17/18 at approximately 7 PM, staff notified the nurse on call, that after a facility search, Resident #2 could not be located. The resident was located some 45-60 minutes after last seen, lying in a snow bank a distance away from the facility. Per care plan review, last updated on 2/2/18, identifies that the resident is an elopement risk. The door in the annex has an alarm that needs to be turned on after 4:30 PM. On 2/26/18 a tracking device was applied to the resident that would identify his/her location, should an elopement occur. The device instructions were located with the care plan. Review of nurses' notes dated 1/24, 2/5 and 2/23/18 identify the following: conduct hourly checks, check regularly, monitor physical proximity more closely and monitor for safety. There is no documented evidence that identifies if any hourly checks were conducted, if a monitoring system was put in place to ensure the resident's presence in the facility or any documentation identifying the residence location or activity attendance at any time. There is no evidence to confirm that the information was communicated to facility staff for it was not included on the care plan. Confirmation was made by the Registered Nurse (RN) and the Licensed Practical Nurse (LPN) on 4/24/18 at approximately 1 PM, that the resident was not appropriately monitored for elopement. It was a well-known fact that other residents were observed shutting the alarm off on the annex door. The nurses could not confirm or deny if the alarm was sounding on the evening of the	R145		

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R145	Continued From page 9 elopement on 3/17/18. The RN and the LPN both confirm that the care plan does not identify Resident #2's needs for 2018.	R145		
R161 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview that facility's Executive Director/Manger failed to ensure that all medications are handled according to the facility's policies and designated staff are fully trained in the policies and procedures. For 1 applicable resident (Resident # 3), the findings include the following: Per record review for Resident #3, with a diagnosis to include, but not limited to Diabetes, has a physician order for Lantus Solostar Insulin 17 units to be administered subcutaneous at bedtime. Facility staff, to include the Medication Technicians, Registered Nurse (RN) and Licensed Practical Nurse (LPN) confirm during interviews, on 4/24/18 at approximately 3 PM, that Resident #3 will not administer the injectable insulin to him/herself. The Medication Administration Record for the months of March and April 2018 identify staff initials as administering the insulin at bed time.	R161		

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R161	Continued From page 10 Facility policy for medications, identifies that ["residents who require insulin administration must be able to self-inject. Their diabetes must be stable enough to maintained on a regular dose of insulin. If the resident can no longer be maintained on a regular dose of insulin they will be assisted to find placement at an appropriate facility."]. Admission agreement signed by the site Manager on 3/22/18 identifies ["if the resident were to become insulin dependent and unable to self-inject insulin, we would need to give notice and find a place for you that offers a higher level of care."] Per discussion with the staff Medication Technicians on 4/24/18, confirmation is made that they have not been taught how to administer Insulin injections. The RN confirms, that Resident #3's blood sugars are not stable, and s/he is not comfortable with the Medication Technicians administering the insulin.	R161		
R168 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: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for	R168		

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R168	Continued From page 11 delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that delegated Medication Technicians administer insulin for 1 applicable resident only when the resident's condition is considered stable by the Registered Nurse (RN), that delegated staff have received additional training in the administration of insulin, and the RN has deemed them competent. For Resident #3, the findings include the following: Per record review for Resident #3, with a diagnosis to include, but not limited to Diabetes, has a physician order for Lantus Solostar Insulin 17 units to be administered subcutaneous at bedtime. The facility staff to include the Medication Technicians, RN and Licensed Practical Nurse (LPN) confirm during interviews, on 4/24/18 at approximately 3 PM, that Resident #3 will not administer the injectable insulin to him/herself. The Medication Administration Record for the months of March and April 2018 identify staff initials as administering the insulin at bed time. Per discussion with the staff Medication	R168		

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R168	Continued From page 12 Technicians on 4/24/18, confirmation is made that they have not been taught how to administer Insulin injections. The RN confirms, that Resident #3's blood sugars are not stable, and s/he is not comfortable with the Medication Technicians administering the insulin.	R168		
R178 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to have sufficient staff available at all times to assure a safe and healthy environment, assure prompt and appropriate action in cases of injury, illness, fire and/or other emergencies. The findings include the following: Per discussion with facility administration on 4/23 and 4/24/18 during the re-licensing survey, confirmation was made that the facility nursing staffing pattern is as follows: Days/Evenings/Night shifts consist of 1 Medication Technician and 1 Resident Attendant (RA). The Registered Nurse (RN) and/or the Licensed Practical Nurse (LPN) is on duty Monday through Friday (business hours). A nurse is on call 24/7. RA's have housekeeping and laundry duties they are also responsible for.	R178		

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R178	Continued From page 13 Resident #2 was admitted to the facility in late September 2017. Numerous elopements occurred during January/February and March of 2018, with the last incident that occurred on a Sunday afternoon, resulting in a hospital admission with a diagnosis of hypothermia, treatment for bruises and abrasions and a review for head and spine injuries. Per record review for Resident #2, nurses' notes dated 1/24, 2/5 and 2/23/18 identify the following: conduct hourly checks, check regularly, monitor physical proximity more closely and monitor for safety. There is no documented evidence that identifies if any hourly checks were conducted, if a monitoring system was put in place to ensure the resident's presence in the facility or any documentation identifying the residence location or activity attendance at any time during the three months that elopements took place. There is no evidence to confirm that the information was communicated to facility staff, for it was not included on the care plan. Confirmation was made by the nurses on 4/24/18 at approximately 1 PM, that Resident #2 was not properly monitored for elopement, that it was a well-known fact that other residents disengaged the door alarm located on the annex door. Ongoing observations could not be accomplished with two (2) staff members in the building. The census at the time of the last elopement was 16. Residents reside on 2 floors, many of which have cognitive impairments and needed assistance for various reasons. The nurses could not confirm or deny if the alarm was sounding on the evening on 3/17/18.	R178		

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	0047	A. BUILDING: _____ B. WING _____	C 04/24/2018

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R179	Continued From page 14	R179		
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 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 employee file review and confirmed by the site Manager, the facility failed to ensure that 5 of 5 staff randomly reviewed, completed the twelve hours of annual training required of direct care givers. The findings include the following: Employee files reviewed on 4/23/18 at	R179		

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R179	Continued From page 15 approximately 5 PM, in the presence of the site manager, disclosed that the following employees #1, #2, #3, #4 and #5 do not have the 12 hours of education required. All five (5) employees have completed 4.5 hours, but topics that have not been included in their annual training are Emergency Response, Respectful Effective Communication and Infection Control.	R179		
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to ensure that 1 applicable resident was free from neglectful care as a result of lack of supervision (Resident #2). The findings include the following: Resident #2 was originally admitted to the facility in late September of 2017. During the first month of admission the resident wandered off the premises without notifying the staff. The resident acknowledged that h/she was not aware of the rule to notify staff. Over the next two months, the resident became more confused and was not fully aware of his/her surroundings/location. At the end of January, the resident was hospitalized for pneumonia and returned to the facility after a 2-day stay.	R224		

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R224	Continued From page 16 Twenty-four hours after returning to the facility, the resident was located outside the building in the evening hours without a coat, in the cold and incontinent of both urine and feces. On two or more occasions over the next month the resident would be located outside of the building. On one occasion staff secured the resident via vehicle, for h/she was walking downtown. Other instances of poor safety awareness by the resident are evidenced in the nurses notes. On Sunday 3/17/18 at approximately 7 PM, staff notified the nurse on call, that after a facility search, Resident #2 could not be located. Staff were instructed to search the grounds and to notify local police and family. The resident was located some 45-60 minutes after last seen, lying in a snow bank a distance away from the facility. Home owners heard someone calling for help and dialed 911. The resident was transported by Emergency Medical Service (EMS) to the hospital emergency room. After evaluation for abrasions/hematomas, and a review for head and spine injuries, the resident was admitted to the acute setting with a diagnosis of Hypothermia and need for monitoring. Per care plan review, last updated on 2/2/18, identifies that the resident is an elopement risk. The door in the annex has an alarm that needs to be turned on after 4:30 PM. On 2/26/18 a tracking device was applied to the resident that would identify his/her location should an elopement occur. The device instructions were located with the care plan. Review of nurses' notes dated 1/24, 2/5 and 2/23/18 identify the following: conduct hourly checks, check regularly, monitor physical proximity more closely and monitor for safety.	R224		

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R224	Continued From page 17 There is no documented evidence that identifies if any hourly checks were conducted, if a monitoring system was put in place to ensure the resident's presence in the facility or any documentation identifying the residence location or activity attendance at any time. Confirmation was made by the nurses on 4/24/18 at approximately 1 PM, that Resident #2 was not properly monitored for elopement, that it was a well-known fact that other residents disengaged the door alarm located on the annex door. Ongoing observations of this resident's safety and whereabouts would be challenging with just two (2) staff members in the building. The census at the time of the last elopement was 16. Residents reside on 2 floors, many of which have cognitive impairments and needed assistance for various reasons. The nurses could not confirm or deny if the alarm was sounding on the evening on 3/17/18.	R224		
R250 SS=C	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 and confirmed by staff interview the facility failed to ensure that outdated canned goods were removed from the premises. The findings include the following: Per observation of the Kitchen on 4/23/18 and	R250		

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R250	Continued From page 18 4/24/18, in the dry storage area, nine (9) cans, each 19 ounces in size, of split pea and lentil soup were on the shelves available for use. The cans were outdated as follows: lentil soup 2017 and split pea soup March of 2018. Confirmation was made by both cooks at the time of discovery.	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 confirmed by the Executive Director, site Director and the Maintenance Director, the facility failed to provide and maintain a safe environment for all fourteen (14) residents residing in the facility. The facility also failed to secure oxygen tanks located in one applicable resident's room. The findings include the following: 1. Per facility tour on 4/23/18 at approximately 2:30 PM the surveyor identified the following and brought the concerns to the attention of administration immediately: The second-floor door located between the construction site and the living quarters of current residents, was found unlocked. The door has a sign that identified [Danger Construction Area	R266		

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R266	Continued From page 19 Keep- Out/Do Not Enter]. There was also caution tape located around the door that was not fully intact and sloughing off. The Registered Nurse confirms at this time that there are four (4) cognitively impaired residents who reside on the second floor, who could wander through the door into the construction site at any time. Administration confirms at this time that they were unaware that the door leading to the construction site was unlocked. 2. The lower level (basement), has a large activity room with a computer and various other supplies available for resident use at all times. Posterior to the computer, are two (2) bookcases with many shelves filled with both hard cover and paper back books. The book cases are free standing, visibly unstable and could easily tip forward or backwards. Administration confirmed that the book cases were a potential harm and were unaware that they had recently been moved. 3. Per facility tour on 4/23/18, Resident #5 has as two full C-Cylinder oxygen tanks and 3-4 small (2 pound) full oxygen tanks located in the resident's bathroom/hall. All tanks are free-standing and not secured. The RN confirms on 4/23/18 that s/her was unaware that the oxygen tanks were present in the resident's room.	R266		

As a result of the survey conducted on April 25th 2018 the below actions have taken place to ensure that we are back in compliance with the cited regulations, and that we continue to maintain compliance.

The plan of correction is the facilities credible allegation of compliance. The filing of this plan does not constitute an admission that the deficiencies alleged did in fact exist. This plan is filed and executed as evidence of Bradley House's desire to comply with the provisions of federal and state law.

1) R101 SS=E Eligibility 5.1

1. Resident #2 has been placed in a higher-level care facility as of Date: 4/4/2018, Resident # 4 was given a 30-day discharge notice with an explanation of the decision. Appeal # 2 is pending. Resident # 3, Bradley House has made an exception to our policy to reflect that insulin may be given as a basal dose on a case to case basis by designated LNA or RA.

2. Discharge notice will be given to any resident who exceeds what care we are licensed to provide. We will contact the agency with our decision.

3. Direct care staff will notify the RN as residents needs increase and the RN will reassess residents for levels of care to determine if resident is appropriate for Residential Level of Care.

4. The RN and the Site Director have reviewed all residents to determine who has care needs that exceed what our home can safely and appropriately provide as of 5/30/2018. We will conduct this review quarterly and on an as need basis.

2) R116 SS=G Discharge and Transfer Requirements 5.3

Emergency Discharge or Transfer of Residents 5.3 b

1. Resident # 4 has returned to Bradley House. The correct form of discharge was submitted to Resident # 4 on 04/09/2018 in the form of a written 30-day notice. Bradley House was granted the 30-day discharge and appeal # 2 is pending.

2. No discharges will take place without both RN and the Site Director discussing and agreeing on what is considered emergent with documented evidence on record.

3. RN and Site Director will meet monthly, and as needed, to review changes in level of care of all residents. This will be documented on each resident's care plan.

4. Bradley House was granted the 30-day discharge and appeal # 2 is pending with the State of Vermont to transfer Resident # 4 to a higher level of care.

3) R128 SS=D General Care 5.5

1. A physician's order from Thomas Evans of Brattleboro VT has been obtained and oxygen tanks will be secured in a 6 cylinder 02 holding rack.

2. All admission orders will be double checked by RN and designated LNA, and all oxygen tanks will be monitored by RN and designated staff daily.

3. Double checking of admissions orders has been added to the admission check sheet. 02 tank checks will be added to the treatment sheets for each shift to monitor.

4. A physician's order from Thomas Evans has been obtained on 5/21/2018 the oxygen tanks were secured in a 6 cylinder 02 holding rack on 4/24/2018. Shift checks of 02 tank security has been added to the TX sheets as of 5/29/2018

4) R145 SS = E 5.9 c

1) Care plans were updated on resident # 1 and history of falls and preventions where added. Resident # 2 was discharged to a higher level of care due to decrease in function. If a situation like resident # 2 happens in the future, increased staff will be put into place until new accommodations can be secured.

2) A care plan update sheet has been placed in the front of the Care Plan chart for RN and LNAs to add any and all changes. Anyone that is known to wander will be given additional staffing until proper placement is found.

3) RN will perform a weekly update of each care plan and on an as needed basis. RN or designee will perform an audit of 3 care plans per quarter to insure all identified needs are addressed.

4) All Care plans are update as of 5/29/2018. They will be completed weekly and on an as needed basis.

5) R161 SS =D Medication Management 5.10

1) Bradley House will train all Medication Technicians to administer basal insulin only.

2) In regards to resident # 3 we are making an exception to our policy to reflect that staff will be able to administer insulin after being educated on procedure of insulin injection for basal insulin only.

3) All Medication technician certified staff that will be designated to give resident insulin will be trained by the RN and signed off in the training records.

4) An addendum was added to Resident # 3's agreement with the Bradley House on March 19, 2018. All Medication Technicians have been trained by the RN as of 5/30/2018

6) R168 SS=D Medication Management 5.10

1) All medical technicians will be trained by the RN to administer basal insulin.

2) Insulin administration education will be added to the education program and, all Medication Technicians will be re-evaluated yearly.

3) All LNA's and RA's that are Medication Technician certified will be deemed competent to administer insulin for resident # 3 by the RN and documented in the education book.

4) All medication Technician certified staff have received additional training on admission of basal insulin as of 5/18/2018 by the RN.

7) R178 SS=G Staff Services 5.11

1) Increased staff will be available at all times to maintain a safe and healthy environment.

2) LNAs will notify RN of any change in status of a resident and increased staffing will be given on a case to case basis.

3) Staff will be given updates on residents increased needs during shift change report and per-diem staff will be added to increase staff to resident ratio during times of high acuity.

4) Increased staff will be available for any resident whose care has advanced until a placement in a higher level of care can be obtained. Resident # 2 has been transferred to a higher-level care facility as of 4/4/2018. Staffing to resident ratio is adequate at this time.

8) 179 SS=F Staff Services 5.11

1) RN will ensure that staff (# 1-5) receive the necessary training before they work with residents.

2) This will be documented on the new training checklist

3) All training will be documented by the RN to include the content and amount of training including any makeup education.

4) Any staff who are currently not up to date in these trainings will complete them by June 22, 2018

9) R224 SS=G Residents Rights 6.12

1) Resident # 2 will be placed in a higher level of care. Due to increased level of care.

2) Bradley House will no longer keep a resident that is a high elopement risk. Staff will report any question of high elopement risk (neglect) moving forward to APS and to Bradley House Management.

3) If a change in care level occurs Bradley House will properly monitor the resident's activities to ensure safety, increase staff and relocate resident to a higher level of care.

4) Resident # 2 was discharged to a higher level of care as of 4/4/2018.

10)R250 SS=C Nutrition and Food Services 7.2

1) Kitchen staff will monitor all stock on a monthly basis and rotate all goods nearing expiration date to the front of the shelves.

2) The food service manager has checked all stock and will do so regularly going forward according to a schedule dictated by Glendale, Bradley House's contracted food service.

3) Bradley House has been in contact with Kitchen staff's local manager and they will also communicate with food services on a monthly basis in order to remain in compliance.

4) All outdated cans have been discarded as of 4/25/2018

11) R 266 SS=F Physical Plant 9.1

1) Bookshelves will be secured; 02 tanks will be secured and door locks will be changed to self-locking.

2) The facility director and site director will conduct monthly safety facility checks.

3) A check sheet will be put into place on 6/4/2018 that will monitor possible safety hazards of the facility. In order to provide a safe and functional environment all necessary repairs/corrections will be made.

4) The basement activity room bookshelves have been relocated on 4/24/2018. 02 canisters were also secured on 4/24/2018. The Facility Director has also educated construction staff on 4/25/2018 about the requirements to keep all construction entrances locked at all times.

As of 4/26/2018 all the construction locks have been changed to self-locking door knobs.

Eileen L. Ogden RN