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 26, 2018

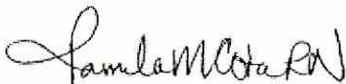
Ms. Cindy Jerome, Manager
The Bradley House
65 Harris Avenue
Brattleboro, VT 05301-2948

Dear Ms. Jerome:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 02, 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 07/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRADLEY HOUSE	65 HARRIS AVENUE BRATTLEBORO, VT 05301

(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 investigation for two complaints was conducted by the Division of Licensing and Protection on 7/2/18. The findings include the following:	R100	See attached Plan of Correction.	
R266 SS=D	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 staff and resident interview, the facility failed to maintain a safe, homelike and comfortable environment for one room on the first floor. The findings include the following: During an observation on a 4/24/18 investigation, one resident room on the first floor was found to have an area between two resident rooms open. The area was developed to provide open access from one room to the other. Two residents share the space. One room is used as a living area and the second room as the bedroom. The opening doorway had not been completed and needed to be framed. At the time of that review, administration was reminded that the space needed to have the exposed sheet rock and rough wood covered. Administration acknowledged the need at that time. Per observation on 7/2/18 at approximately 8:15 AM, the opening between the two rooms has not	R266		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], SITE DIRECTOR INTERIM MANAGER | TITLE | (X6) DATE 07/20/2018

R266 POC accepted 7/24/18 MBertrand RN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R266	Continued From page 1 been completed. The door is not framed, sheet rock is still exposed and the edges are rough. Confirmation was made by the two residents occupying the space on 7/2/18 at approximately 8:15 AM and again at 2 PM, that Resident #1 sustained an injury to the 4th toe of the left foot, while wearing a soft shoe and sock, after bumping the foot against the rough edge of the sheet rock and wood. The resident was attempting to pass from one room to the other with a walker. The Registered Nurse can not confirm how the resident injured his foot, but Resident #1 has required a wound care to include a dressing application during the months of June and July to date.	R266		

As a result of the survey conducted on July 2, 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) R266 SS=D Environment 9.1

1. The open doorway has been framed and a door has been placed in the opening as of July 9, 2018

2. Any and all maintenance or construction needed in resident's rooms will be completed in a timely manner to ensure that there is a safe and comfortable environment.

3. Monthly rooms checks will be conducted in each resident's room to determine if there are any maintenance needs.

4. The door frame was completed on July 9, 2018.

Eileen L. Ogden RN