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 9, 2023

Mr. Robert Crego, Manager
The Bradley House
65 Harris Avenue
Brattleboro, VT 05301-2948

Dear Mr. Crego:

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
	0047	A. BUILDING: _____ B. WING _____	05/03/2023

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 onsite re-licensure survey was conducted by the Division of Licensing and Protection on 5/2/23 with offsite record review of facility provided information on 5/3/23. There were regulatory deficiencies identified as a result of the survey. Findings include:	R100	See Attached P.O.C.	
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that an admission assessment was completed for 1 of 5 Residents (Resident #1) in the sample within 14 days of admission. Findings include: Per record review Resident #1 was admitted to the facility on 5/24/22. An assessment dated 7/21/21 that was completed while the Resident resided at another facility was located in the chart. However, there was no evidence that an assessment had been completed since admission. Per interview with the Registered Nurse on 5/2/23 at 2:35 PM Resident #1 was transferred from a	R134		

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R134	Continued From page 1 "sister" facility that had closed. S/he is not sure why there would not be an admission assessment in the record.	R134		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Registered Nurse (RN) failed to ensure 1 out 5 resident records contained annual reassessment and significant change assessments. Findings include: Per record review Resident #2 was admitted to the resident care home on 7/7/21, an annual reassessment was not completed in the year 2022, additionally the record did not contain a change in condition assessment to identify care needs related to admission to hospice services on 3/23/23. An interview on 5/2/23 at 3:15 PM, the RN confirmed the record did not have an annual reassessment and a change in condition assessment in the resident record.	R136		

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R179	Continued From page 2	R179		
R179 SS=E	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 record review and staff interview the facility failed to ensure 4 out of 5 staff completed 12 hours of required training for staff providing direct care to residents. Findings include: Per staff file review, 4 out 5 staff did not complete all of the 12 hours of required annual training.	R179		

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R179	Continued From page 3 The review of the education files indicated 3 out 5 staff did not complete annual training for Resident Rights, 1 out of 5 did not complete an annual training for Fire Safety, 3 out 5 did not complete an annual training for Emergency Response/First Aid, 2 out of 5 did not complete an annual training for Abuse, Neglect and Exploitation. During an interview on 5/2/23 at 12:30 PM the Registered Nurse confirmed that 4 out of 5 staff did not complete all of the required mandatory training. The nurse acknowledged the requirement for the annual trainings and the required topics.	R179		
R220 SS=C	VI. RESIDENTS' RIGHTS 6.8 A resident may complain or voice a grievance without interference, coercion or reprisal. Each home shall establish a written grievance procedure for resolving residents' concerns or complaints that is explained to residents at the time of admission. The grievance procedure shall include at a minimum, time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the Office of the Long Term Care Ombudsman and Vermont Protection and Advocacy as an alternative or in addition to the home's grievance mechanism. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility policies the facility failed to establish a written grievance	R220		

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R220	Continued From page 4 procedure to ensure Residents' concerns or complaints are resolved. Findings include: During interview on 5/2/23 at approximately 4:45 PM the Executive Director (ED) was asked to provide the written grievance procedure that is explained to Residents on admission. ED confirmed that the facility does not have a written grievance policy that includes the grievance procedure, time frames, the process for responding to residents in writing and the method of filing a grievance with the Office of the Long Term Care Ombudsman and the Vermont Protection and Advocacy in addition to the home's grievance mechanism.	R220		
R247 SS=E	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 of the dietary services, the facility failed to ensure proper labeling and dating of perishable items in the kitchen. Findings include: Per observation of the dietary kitchen area, within the walk in refrigerator the following items were found in unlabeled storage container and with out date items were prepared: 2 containers of dressings, a container of prepped lettuce, a	R247		

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R247	Continued From page 5 container of shredded cheese and a container of sliced olives. Per interview with the Dietary Manager on 5/2/23 at 10:10 AM the items that were observed unlabeled and without dates had been prepped for the salad bar for the lunch serving. S/he stated that this is done daily, and confirmed the requirement for proper labeling and dating of items to ensure proper handling and disposal.	R247		

BRADLEY HOUSE PLAN OF CORRECTION
6/1/2023

5.7 Assessment

5.7 a. An assessment shall be completed for each resident within 14 days of admission……

What action you will take to correct the deficiency: *Resident #1 will be assessed to correct this deficiency.*

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: *All new admissions will be scheduled for an assessment within 14 days of admission.*

How the corrective actions will be monitored so the deficient practice does not recur: *The Admissions Coordinator will collaborate closely with the Clinical Director to ensure that all administrative and care-related requirements for a new admission are scheduled and met.*

The dates corrective action will be completed: *Resident #1 was assessed on May 3, 2023*

tag R134 Accepted on 6/9/2023 -C.Scott/J. Shea

5.7 Assessment

5.7 c. Each resident shall also be reassessed annually and at each point in which there is a change in the resident's physical or mental condition.

What action you will take to correct the deficiency: *Resident #2 will have a change of assessment completed to reflect current care needs.*

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: *We will institute regular chart reviews to ensure that all residents are being reassessed annually and that reassessments are occurring when there is a change in a resident's physical or mental condition.*

How the corrective actions will be monitored so the deficient practice does not recur: *The Clinical Director and LPN will perform quarterly reviews of all resident files. They will use a checklist of required file items with dates for completion/review/reassessment.*

The dates corrective action will be completed: *The change of status assessment for Resident #2 was completed on May 2, 2023; we will start a quarterly review of all resident files in July and thereafter in October, January, and April.*

tag R136 Accepted on 6/9/2023 -
C.Scott/J. Shea

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….

What action you will take to correct the deficiency: *We have created and are implementing an orientation process that will be required of all new direct-care staff before they can provide care to residents. This orientation includes the following learning modules: Resident Rights, Fire Safety and Emergency Evacuation, Resident Emergency Response Procedures, Mandatory Reporting of Abuse, Neglect and Exploitation, Respectful Interactions with Residents, Infection Control Measures, and General Supervision and Care of Residents. To facilitate this process, we have re-subscribed to Relias Systems for on-line training; we have designated two laptops with headphones to be used for training, and assigned the Front Desk LNA to review training requirements with staff, provide support and track/record individual progress to ensure compliance. This position has also been tasked with reviewing the training records of all current staff to identify deficiencies and create individual training plans to address these deficiencies. Undivided time to do on-line training will be built into the weekly schedule to ensure that it is completed without compromising the delivery of care.*

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: *As discussed above, we now have an orientation process to ensure the all new hires meet the foundational requirements for skill competency. Having equipment and software devoted to training, scheduling staff to devote undivided time to training during work hours, and having a staff member responsible for overseeing the process will all help to ensure success in this area.*

How the corrective actions will be monitored so the deficient practice does not recur: *Using the Relias training system which produces reports on all staff training, will ensure that all staff complete required training and achieve the necessary skills and competency*.

The dates corrective action will be completed: *All new hires are now undergoing the orientation process outlined above. Current staff who are deficient in requirements have been assigned training modules through Relias to complete these deficiencies. Current staff who are deficient in required training should be compliant by June 30.*

tag R179 Accepted on 6/9/2023 - C.Scott/J. Shea

6.8 Resident Rights

6.8 A resident may complain or voice a grievance without interference, coercion or reprisal. Each home shall establish a written grievance procedure for resolving residents' concerns or complaints that is explained to residents at the time of admission….

What action you will take to correct the deficiency: *We have created a grievance policy and procedure to address this deficiency (see attached).*

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: *This policy has been made a part of our admissions procedure; staff reviews the grievance procedure with new residents, who acknowledge their review by signing and dating a copy of the policy and procedure. The procedure will also be reviewed with all current residents; they will be given copies and will sign and date, signifying their acknowledgement.*

How the corrective actions will be monitored so the deficient practice does not recur: *The grievance policy and procedure will be made a part of our polices and procedures handbook; a record of written grievances and responses will be maintained and reviewed to inform quality improvement.*

The dates corrective action will be completed: *The grievance procedure is now a part of our admission documents; all current residents will review and acknowledge the grievance procedure by the week of June 4.* tag R220 Accepted on 6/9/2023 - C.Scott/J. Shea

7.2 Food Safety and Sanitation

7.2 b. All perishable food and drink shall be labeled, dated and held at proper temperatures….

What action you will take to correct the deficiency: *We will ensure that all perishable food and drink is labeled, dated, and held at proper temperature.*

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur*: Staff of Glendale Senior Dining, our food service contractor, have reviewed* guidelines for *proper handling and disposal requirements for prepped and leftover TCS and non-TCS foods, detailed in Glendale's Dating Food Guidelines (see attached), and have signed off on their understanding. Glendale will also implement a labelling tool called Date Code Genie, which prints food labels with a "made" date and "use-by" date. Content is regularly created, managed and updated by Glendale electronically to ensure that content is current and correct. Glendale will install and provide training to staff on the proper use of the tool*

How the corrective actions will be monitored so the deficient practice does not recur: *Continued oversight and compliance will be monitored by the food and nutrition staff.*

The dates corrective action will be completed: *The Date Code Genie has been shipped to Glendale. They anticipate receiving and setting up the equipment by the week of June 4; staff will then be training by the week of June 11.* tag R247 Accepted on 6/9/2023 - C.Scott/J. Shea

BRADLEY HOUSE
A Garden Path Elder Living community
NON-PROFIT ◆ FOUNDED IN 1964
CARING FOR YOUR FAMILY AS OUR OWN

GRIEVANCE POLICY AND PROCEDURE

Policy: Resolving a resident's grievance is a priority. Bradley House will assure that all residents and their family members/representative have access to and understand the Grievance Procedure in the event a concern or complaint about their care or treatment arises.

Definition: A grievance is a wrong or a hardship suffered, real or supposed, which forms legitimate ground for complaint.

Procedure: If a resident feels that they are being treated unfairly by a staff member, or that a policy or practice is unfair, they are encouraged to voice a grievance as follows:

1. First, speak with either the Human Resources Coordinator (Leigh Niland) or the Clinical Director (Cyndy Channing). Be specific in describing your situation. If you are unable to reach a satisfactory solution;

2. Put your complaint in writing to the Executive Director (Bob Crego). The Executive Director will respond to you in writing within five working days and meet with you to discuss the response. If you are not satisfied with the response and/or would like outside help, you may:

3. Contact the Vermont Long Term Care Ombudsman. The Long-Term Care Ombudsman Project protects the health, welfare and rights if people who live in licensed long-term care facilities. They will meet with you and attempt to mediate your grievance and can advise you on the best course of action to take. The contact information for the Vermont Long-Term Care Ombudsman in our area is as follows:

   Kerry White
   Vermont Legal Aid
   56 Main Street, Suite 301
   Springfield, VT 05156

   Phone: 802-448-6944 or toll free, at 800-889-2047

4. You may also contact Vermont Protection and Advocacy, a statewide agency dedicated to advancing the rights of people with disabilities. Their contact information is as follows:

   Vermont Protection and Advocacy, Inc.
   141 Main Street, Suite 107
   Montpelier, VT 05602.

   Phone: (802) 229-1355 or toll free, at (800) 834-7890