VERMONT

**Department of Disabilities, Aging and Independent Living**
**Division of Licensing and Protection**
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*AGENCY OF HUMAN SERVICES*

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

November 18, 2025

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 November 3, 2025**. 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 |
|---|---|---|---|
| | 0047 | A. BUILDING: _____ B. WING _____ | 11/03/2025 |

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

R159, R225, and R378
Accepted 11-17-25
Susan Canas Gregoire RN

| (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<br><br>On November 3, 2025 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey. The following deficiencies were identified: | R100 | | |
| R159 SS=D | 5.9.c (2) Nursing Services<br><br>For each resident requiring a nursing overview, administration of medication, or nursing care, the registered nurse must:<br><br>Develop a person-centered written plan of care within 14 days after admission, in accordance with the nursing process and professional standards of practice, for each resident that is based on abilities and needs as identified in the resident assessment. The resident, and if the resident chooses, resident representatives such as family or close supports, must be invited and allowed to participate in care planning meetings. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being, and must be revised as the resident?s abilities and needs change<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the home failure to ensure the development of a person-centered written plan of care that identified goals and interventions to address a Resident's (Resident #1) fall risk, changing abilities and overall well-being. Findings include:<br><br>The home's Service/Care Plan policy is | R159 | SEE ATTACHED | |

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| R159 | Continued From page 1<br>consistent with this licensing rule.<br><br>Per record review of Resident #1's care plan on the afternoon of November 3, 2025, the plan identifies the resident as having cognitive and physical impairments, including neuropathy, and requiring use of a walker and assistance with activities of daily living. The progress notes document the history of recurrent falls; however, the care plan does not address risk for injury, safety precautions, monitoring interventions, or assessment related to falls. In addition, there was no evidence of a completed fall risk assessment tool, or inclusion of cognitive or behavioral care plan components to address impulsiveness or poor safety judgment pertaining to falls.<br><br>Per record review of the home's incident reports for Resident #1, conducted on the afternoon of November 3, 2025, Resident #1 had documented fall incidents on February 11, May 2, September 24, October 15, 2025 and October 29th, 2025. Review of the Resident's progress notes further indicated that Emergency Medical Services were dispatched to the home in response to falls resulting in documented injuries on December 27, 2024, February 12, 2025, September 24, 2025, and October 29, 2025.<br><br>Despite multiple documented falls and injuries, the home failed to revise or update Resident #1's plan of care or to complete a fall risk assessment to ensure that appropriate interventions were implemented to prevent recurrence.<br><br>These findings were confirmed by the Registered Nurse on the afternoon of November 3, 2025. Upon review of Resident #1's care plan, the Registered Nurse acknowledged that the risk of falls had not been addressed and initiated | R159 | | |

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| R159 | Continued From page 2<br>revisions to update the care plan. | R159 | | |
| R225 SS=F | 5.12. b (4) Records/Reports<br><br>The home must keep and maintain the following records:<br><br>The results of the criminal record and adult abuse registry checks for all staff:<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review there is a failure to ensure all background checks were completed as required for one out of five staff. Findings include:<br><br>The home's background check policy is consistent with the State Licensing Rules.<br><br>On the morning of November 3, 2025, documentation of criminal record and abuse registry checks was requested for a sample of five staff. Background check documentation for four of the five staff was provided and verified as completed in accordance with State Rules. However, documentation of a background check for one of the sampled staff was not provided for review and therefore could not be verified as completed or compliant with State Licensing Rules.<br><br>This finding was confirmed by the Human Resources Director of the home on the afternoon of November 3, 2025 | R225 | | |
| R378 SS=F | 7.1.a (10) Menus And Nutritional Standards<br><br>The home must provide or obtain appropriate | R378 | | |

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| R378 | Continued From page 3<br>education and training for its chief food service staff to ensure the proper preparation and storage of all food items. The training provided to each staff must be documented by the home.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the home failed to provide documentation demonstrating completion of required training for a chief food service staff member. Findings include:<br><br>The home staff training policy is consistent with the State Licensing Rules<br><br>On the morning of November 3, 2025, the Manager of the home was requested to provide documentation of the required training completed by a chief food service staff member. Following this, and subsequent requests on the afternoon of November 3, 2025, no documentation was provided to review. As a result, the home was unable to demonstrate compliance with State Licensing Rules regarding required staff training.<br><br>This finding was confirmed by the Manager on the afternoon of November 3, 2025. | R378 | | |

**PLAN OF CORRECTION**
**BRADLEY HOUSE**
**11/14/2025**

The following are the plans that have been formulated to address the citations detailed in the re-licensing report:

**R159 5.9 c (2) Nursing Services: For each resident requiring a nursing overview, administration of medication, or nursing care, the registered nurse must develop a person-centered written plan of care, etc.**

*How the deficiency was corrected*

An updated care plan for the resident in question was completed on November 3, 2025.

*How other potential residents have been identified, and the corrective action taken*

We are addressing this issue by reviewing all the incident reports and transfers out to hospital in the past six months and ensuring that all care plans for those residents have been updated. This reviews and update of all care plans will be completed by November 18, 2025.

*System changes taken to ensure compliance with the regulation*

We are in the process of making two system changes. All care plans going forward will be entered directly into Point Click Care. This will do away with paper plans. This will make plans easier to review and update. We are also adding a sign off on our incident report forms that indicates that the RN who reviews/signs off also must indicate that the care plan has been updated accordingly.

R159 Accepted 11-17-25
Susan Canas Gregoire RN

*Who will monitor to ensure compliance*

The Clinical Director will ensure compliance.

**R225 5.12 b (4) Reports/Records: The home must keep and maintain the following records: The results of criminal record and adult abuse registry checks for all staff.**

*How the deficiency was corrected*

Garden Path Elder Living (Bradley House) conducted criminal background and adult abuse and child abuse registry checks for two kitchen staff members on November 4, 2025 and for a third kitchen staff member on November 6, 2025. The results of the checks are on file in the HR office.

*How other potential residents have been identified, and the corrective action taken*

This corrective action will help to ensure the health and safety of all Bradley House residents.

*System changes taken to ensure compliance with the regulation*

Going forward, Garden Path's HR Coordinator will do annual background checks on all contracted kitchen staff. This practice has been accepted by the food service vendor. The HR Coordinator has added the kitchen staff employees to the calendar for annual re-checks.

*Who will monitor to ensure compliance*

R225 Accepted 11-17-25
Susan Canas Gregoire RN

The Administrator will be responsible for ensuring compliance by reviewing the staff roster each month with the HR Coordinator to ensure that all staff have had successful background checks within the preceding 12 months.

**R378 7.1 a (10) Menus and Nutritional Standards: The home must provide or obtain appropriate education and training for its chief food service staff…**

*How the deficiency was corrected*

On November 4, 2025, Garden Path Elder Living (Bradley House) obtained from its food service vendor copies of ServSafe Food Production Manager certifications for all of its kitchen staff. These certificates have been filed on site in the administrator's office.

*How other potential residents have been identified, and the corrective action taken*

Ensuring that food service staff are trained in food safety regulations and sanitary practices will help ensure the health and safety of all residents.

*System changes taken to ensure compliance with the regulation*

The food service vendor will provide proof of ServSafe certification for all new employees, as well as renewed certification for existing employees. The certifications are filed along with the company's current COI, annual approved budget, and contract in the Administrator's office, and will become part of the documentation we review annually when we approve the food service budget.

*Who will monitor to ensure compliance*

R378 Accepted 11-17-25
Susan Canas Gregoire RN

The Administrator will be responsible for ensuring compliance.