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

March 31, 2026

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 **March 2, 2026.** 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

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
	0657	A. BUILDING: _____ B. WING _____	03/02/2026

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 On March 2, 2026, the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey. The following deficiencies were identified:	R100	R105, R114, R206,R210, R215, R223, R358, R381, R401, R443, R451 Accepted 3-27-2026 Susan C Gregoire RN	
R105 SS=C	5.2.a Uniform Consumer Disclosure-Admit Agreements The licensee upon initial licensure must state the services it can and will provide, the public programs or benefits that it accepts or delivers, the policies that affect a resident's ability to remain in the home, and any other relevant information. (1) The uniform consumer disclosure must be completed on a form provided by the licensing agency and must be kept on file by the licensee. (2) The uniform consumer disclosure must include a statement describing the daily, weekly or monthly rate to be charged, a description of the services that are covered in the rate and all other applicable financial issues. (3) The uniform consumer disclosure must include a statement that rates are subject to change, including rate changes due to increased care needs,and describe the situations in which the changes (s) could occur. (4) The uniform consumer disclosure must be provided; i. to residents prior to or at admission and at any time it is changed or is requested by the resident; and ii. to the public upon request (5) The availability of a uniform consumer disclosure must be noted prominently in all marketing brochures and written materials.	R105		

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R105	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there is a failure to provide all residents with a Uniform Consumer Disclosure. Findings include: The facility's Admission policy does not include information regarding the Uniform Consumer Disclosure. Per staff interview, the Uniform Consumer Disclosure is not provided to all residents upon admission nor to current residents of the facility. This was confirmed by the Manager of the facility on 3/02/2026 at 3:15 PM.	R105		
R114 SS=C	5.2.d Uniform Consumer Disclosure-Admit Agreements A home that has specialized programs or care units such as dementia care must include a written statement of philosophy and mission and a description of how the home can meet the specialized needs of residents in its uniform consumer disclosure form and in its admission agreement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R114		

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R114	Continued From page 2 licensee failed to ensure that the home's admissions agreement and Uniform Consumer Disclosure Form included a written statement of the home's philosophy and mission, and a description of how the home meets the specialized needs of residents served in the special care unit, as required by state rules. Findings include: The homes Admissions Policy did not address content requirements for the admissions agreement or the Uniform Consumer Disclosure Form. During the facility survey conducted on the morning of March 2, 2026, the Manager and Registered Nurse were requested to provide all admission documents provided to residents at the time of admission, including documents signed by residents upon agreement to reside in the home. Per record review conducted on the morning of March 2, 2026, the Manager provided the home's admission agreement. Review of the document indicated that it did not include the required written statement of the home's philosophy and mission or a description of how the home meets the specialized needs of residents served in the special care unit as required by state rules. Per interview conducted with the Manager on the morning of March 2, 2026, the Manager acknowledged that the Uniform Consumer Disclosure Form had not been used or provided to residents upon admission and had not been provided to residents currently residing in the home. These findings were confirmed by the Manager on the afternoon of March 2, 2026.	R114		

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R206 SS=F	5.10.h (4) Medication Management Medications left after the death or discharge of a resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there is a failure to ensure prompt disposal of outdated medications. Findings include: The facility's Medication Management policy is consistent with licensing rules. The following outdated medications observed to be stored in the facility's medication room include, but are not limited to: 1. Desitin cream, expired 08/2025 2. Docusate Sodium capsules 100mg, expired 8/05/2025 3. Diphenhydramine capsules 25mg, expired 6/14/2025. 4. Melatonin tablets 5mg, expired 05/2020 This was confirmed by the RN at 12:05 PM and by the Manager on 3/02/2026 at 3:15 PM.	R206		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of	R210		

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R210	Continued From page 4 training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review 3 out of 5 sampled staff did not complete the required trainings. Findings include: The facility's Staff Orientation Training Policy is consistent with licensing rules.	R210		

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R210	Continued From page 5 Documentation of training completed by 5 sample staff was requested on the morning of 3/02/2026. Per review of the documentation provided, the required trainings were not completed by 3 out of 5 sampled staff. This was confirmed by the Manager of the facility at 3:15 PM on 3/02/2026.	R210		
R215 SS=F	5.11.e (4) Staff Services All background checks must be rechecked based on facility policy. The policy must include, at a minimum an annual re-check of Vermont criminal and abuse registries, and an annual re-check of all jurisdictions if a staff member has worked or lived in another state since the initial background check was completed and/or does so on a regular basis, and at any time any employee or caregiver notifies the home of a conviction or substantiation. This REQUIREMENT is not met as evidenced by: Based on record review 5 out of 5 sampled staff did not have up-to-date required background checks. Findings include: The facility's Staff Services policy has not been updated to align with current licensing rules. Documentation of background checks completed on 5 sampled staff was requested the morning of 3/02/2026. Per review of the documentation provided, the required national criminal background checks were not completed by the facility. In addition, annual re-checks of applicable	R215		

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R215	Continued From page 6 abuse registries were not completed. This was acknowledged by the Manager of the facility on the afternoon of 3/02/2026.	R215		
R223 SS=E	5.12.b (2) Records/Reports The home must keep and maintain the following records. A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; licensed health care provider ' s name, address and telephone number; instructions in case of resident ' s death; the resident ' s assessment(s); progress notes regarding any accident or incident and subsequent follow-up; progress notes regarding any illness or change in condition and subsequent related follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident ' s advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the licensee failed to ensure that a recent photograph of each resident was maintained in resident records. Findings include: Per record review conducted on the morning of	R223		

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R223	Continued From page 7 March 2, 2026, 6 of 10 resident records reviewed, did not contain a recent photograph of the resident on file as required by state rules. Per interview conducted with the Manager on the afternoon of March 2, 2026, the Manager confirmed that resident photographs had not been taken.	R223		
R358 SS=F	6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure residents' right to privacy related to records containing protected health information. Findings include: The facility's policy, Confidentiality of Resident Information, states that resident records are legal documents and must be kept confidential. The policy states that resident information may only be used for the purpose of providing appropriate care and services to the residents and any information by or about a resident that is shared must be treated as confidential. The policy further	R358		

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R358	Continued From page 8	R358		

states that any breach of confidentiality constitutes a violation and may result in disciplinary action. The policy defines protected health information as all healthcare information, whether written, spoken, or transmitted by a provider, that must be maintained in accordance with privacy standards. The policy further states that the nurse's station must be an enclosed area and that all resident records, including medication administration records (MARS) and other medical records containing protected health information, must be maintained in a protected area.

Per observation during the facility tour conducted on the morning of March 2, 2026, the main medication room, located in the first-floor common area and used to store resident medications, was observed to be open and unsecured. The door to the medication room had been propped open with a stool. On a counter within the medication room, a narcotic bottle count sheet was observed containing resident identifying information including resident name, medication name, dosage, and staff documentation of medication administration. Further observation revealed that all resident records were maintained in an unsecured cabinet within the open medication room. Records observed included documentation containing resident diagnosis, medication management records, physician visit documentation, incident reports, consent to release forums, and resident demographic information.

Per additional observation during the facility tour conducted on the morning of March 2, 2026, revealed that documents containing resident identifying information were also maintained unsecured in the medication room of the special care unit. Documents observed included faxes,

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R358	Continued From page 9 physician orders, and behavioral shift documentation identifying residents by name and containing information related to resident behaviors and assistance required with activities of daily living. These documents were maintained within the unsecured medication room and accessible to individuals entering the area including residents, visitors and staff These findings were acknowledged by the Manager and the Registered Nurse on the afternoon of March 2, 2026.	R358		
R381 SS=F	7.2.a Food Safety and Sanitation Each home must procure food from sources that comply with all laws relating to food and food labeling. The home must ensure that all food is safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks must be rejected and kept separate until returned to the supplier. This STANDARD is not met as evidenced by: Based on observation and staff interview, the home failed to ensure that all perishable food was properly labeled, dated and stored in closed, sanitary packaging, and that dented cans were removed from food storage areas as required by State Rules. Findings include: The home's Food Storage and Equipment Policy states that food service staff will store all food and maintain kitchen equipment in a safe and sanitary manner in compliance with all applicable regulations. The policy includes that dry storage	R381		

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R381	Continued From page 10 is appropriate for nonperishable items such as canned goods, flour, sugar, salt, and dry cereals in a protected containers at least eight inches off the floor and maintained at a temperature between 40 and 70 degrees Fahrenheit. The home's Food Safety Policy states that no outdated, dented, or unlabeled foods will be present or utilized. Per observation during a tour of the home's kitchen and food storage areas conducted on the morning of March 2, 2026, several food storage concerns were observed. In the dry storage area, dented cans of cherry pie filling and peach pie filling were observed on the shelving. Two bottles of Ensure Nutritional Original Shake dated 2020 were also observed on the shelf and available for service. The temperature of the dry storage area was observed to be 82.9 degrees Fahrenheit. Cans of Chicken of the Sea Chunk White Albacore Tuna were stored in this area, the container label of which states to store in a cool, dry place. Unlabeled cereal and other unlabeled food items were also observed in the dry storage area. Further observation of the refrigerator in the main kitchen food storage area revealed wilting celery, unlabeled pasta and unlabeled lunch meat. These findings were acknowledged by the Manager on the afternoon of March 2, 2026.	R381		
R401 SS=F	9.1.a Environment The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This includes outdoor areas that are used by residents.	R401		

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R401	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the licensee failed to ensure that the home maintained a safe, sanitary and homelike environment. Findings include: The home's Physical Plant Environmental Policy states that the home will provide and maintain a safe, functional, sanitary, home-like and comfortable environment. Per observation on the facility tour conducted on the morning of March 2, 2026, thick untreated ice was observed covering the exterior steps immediately outside an emergency exit located on one wing of the main floor of the home. The ice extended across the walking surface of the steps. Observation during the facility tour conducted on the morning of March 2, 2026, revealed a large opening in the ceiling located in a main common hallway used by residents and staff of the home. The opening exposed ceiling materials including wooden boards, ceiling panels, insulation, and areas of visible water damage. Per observation during the facility tour conducted on the morning of March 2, 2026, multiple cleaning products, chemical agents, and pest control substances were observed stored in unsecured and accessible areas throughout the home. Items observed included cleaning products such as toilet bowl cleaner, glass and window cleaner, floor cleaner, stain remover, disinfectant products containing bleach, ammonia-based cleaners, and pest control substances including insect sprays and rodent control products. These	R401		

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R401	Continued From page 12 items were observed stored unsecured in multiple locations throughout the home, including the main medication room, the special care unit, a storage closet located in a common hallway, an open shelf located in a common living room area, the salon area, and the downstairs maintenance room. During the facility tour conducted on the morning of March 2, 2026, the downstairs maintenance room door was observed open and accessible from a common area of the home. Inside the room, multiple tools and maintenance items were observed stored in an unsecured manner, including drills, wrenches, scissors, nails, and other hand tools. Additional items observed included exposed wiring, tubing, and mechanical equipment associated with the home's utility systems. A heating unit with a visible flame and posted warning signage indicating the presence of electrical lines was also observed within the room. These items were accessible due to the maintenance door being open and unsecured allowing potential resident access to tools, sharp objects, mechanical equipment, and utility components. The presence of unsecured chemicals, pest control products, tools, sharp objects, and maintenance equipment in areas accessible within the home, along with the observation of untreated ice accumulation at an emergency exit and a large opening observed in the ceiling, creates the potential for resident exposure to hazardous substances, objects and environmental hazards and does not support the maintenance of a safe and home-like environment for residents of the home. These findings were acknowledged by the	R401		

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R401	Continued From page 13 Manager on the afternoon of March 2, 2026.	R401		
R443 SS=F	9.11.d Disaster and Emergency Preparedness There must be an operable telephone on each floor of the home, available to residents at all times. A list of emergency telephone numbers must be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the licensee failed to ensure that operable telephones accessible to residents with a list of emergency telephone numbers posted by each telephone were available on each floor of the home at all times. Findings include: The home's Disaster and Emergency Preparedness Policy state that an operable telephone must be available on each floor of the home for residents use at all times and that a list of emergency telephone numbers must be posted by each telephone. During a tour of the home conducted on the morning of March 2, 2026, the survey team observed there was not an operable phone accessible to residents with emergency numbers posted beside it on all three floors of the home. This finding was confirmed by the Manager on the afternoon of March 2, 2026.	R443		
R451 SS=F	10.2.e Pets Pets, owned by a resident or the home, may reside in the home providing the following conditions are met:	R451		

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BROMLEY MANOR	2595 DEPOT STREET MANCHESTER CENTER, VT 05255

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R451	Continued From page 14 Pet health records must be maintained by the home and made available to the public This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the licensee failed to ensure that health records for a pet owned by a resident of the home were maintained and available, as required by state rules. Findings include: The home's Pet Policy states that the pet owner will provide information identifying the pet, current and annual proof of vaccinations, and the name and address of the veterinarian responsible for the pet's care. Per observation during the facility tour conducted on the morning of March 2, 2026, a cat was observed sleeping in a resident's room. The cat was confirmed to reside in the home. Per record review conducted on the morning of March 2, 2026, health records for the pet were requested; however, no health records for the pet were maintained on-site or available for review. The manager of the home acknowledged these findings on the afternoon of March 2, 2026.	R451		

Deficiency Statement Plan of Correction (POC)

Survey Date: 3/2/26

Facility Name: Bromley Manor

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R105	Universal Disclosure Agreement is included in all admission packets and has been distributed to all residents and/or families of current residents where missing.		In Process 60% complete	Follow up on all missing docs Will be conducted weekly R105 Accepted 3-27-2026 Susan C Gregoire RN	Administrator
R114	Mission Statement and philosophy added to UDA stating that Care Plan is an individual assessment of resident needs to ensure that they receive the highest level of compassionate personalized support.		3/23/26	R114 Accepted 3-27-2026 Susan C Gregoire RN	Administrator
R206	All med carts were reviewed for former residents medication and outdated medications.		3/4/26	Med carts will be inventoried weekly by med techs.	RN R206 Accepted 3-27-2026 Susan C Gregoire RN
R210	Training will include a minimum of 12 hours for all staff with additional training regarding trauma informed care and with sensitivity towards other cultures, belief systems. Etc.			Training will be provided to all new hires and to all staff on an annual basis. Outside providers will be utilized for a comprehensive program with the oversight of our nurse.	RN R210 Accepted 3-27-2026 Susan C Gregoire RN

R215	Background checks were audited for Criminal, Adult, Child, and National checks. All employees files have been updated with current checdks		3/19/26	Files will be audited on an annual basis in March of every year.	Admin Asst R215 Accepted 3-27-2026 Susan C Gregoire RN
R223	Photos were missing from resident files.	R223 Accepted 3-27-2026 Susan C Gregoire RN	3/19/26	Each new resident will be photographed on the day of admission.	Admin Asst
R358	Resident Confidentiality was not maintained. Subsequently, all cabinet locks are in use of resident files, narcotics book has been relocated to the locked med cart and med tech offices will be locked when not in use		3/5/26	Dailly checks will be conducted to ensure secured files R358 Accepted 3-27-2026 Susan C Gregoire RN	Admin & RN
R381	Food Safety-All dented cans will be returned to vendor. Outdated cans will be destroyed. All food will be labeled, and dated. Outdated food will be tossed.		3/5/26	Fridge and walk-in will be reviewed weekly R381 Accepted 3-27-2026 Susan C Gregoire RN	Chef
R401	Home will be maintained in a safe and sanitary condition.	R401 Accepted 3-27-2026 Susan C Gregoire RN	3/3/26	Ice was removed from steps and ice dam on roof was tended by a roofing contractor. Subcontractor has been hired to repair sheetrock. Roofer is coming to inspect area of ice dam and roof leak.Exit doors inspected	Administrator
R401	Unsecured chemicals are stored in secured areas in AL, Memory			Adams Lock & Key installing push button locks on doors	Administrator

	care and in kitchen cabinet.			and cabinets installed in kitchen	
R401	Maintenance Room And Beauty Salon		3/3/26	Maintenance Room and salon have been locked at all times. Hairdresser advised.	Administrator
R443	Telephones not available on all floor.	R443 Accepted 3-27-2026 Susan C Gregoire RN	In process	Met with IT contractor who is designing system for upper and lower level phone access	Administrator
R451	Pets in building	R451 Accepted 3-27-2026 Susan C Gregoire RN		Pet owned by resident has papers on file. Family members with pets have been notified and papers obtained	Administrator