

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Bel-Air Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 256 New Britain Avenue Newington, CT 06111	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for change in condition, the facility failed to ensure the resident's Power of Attorney was notified timely of a hospital transfer and medication changes. The findings include:</p> <p>Resident #2's diagnoses included congestive heart failure, chronic kidney disease, tremors, and anxiety.</p> <p>Review of Resident #2's advance directives dated 12/4/2017 identified Person #2 was the medical Power of Attorney (POA).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of intact cognition and required set-up assistance for ADLs (activities of daily living). The Resident Care Plan (RCP) dated 8/23/2024 identified Resident #2 had ineffective airway clearance. Interventions directed to administer medications as ordered, monitor resident for signs and symptoms of pneumonia, and update the family with any changes in resident's condition.</p> <p>A.</p> <p>A nursing note dated 9/1/2024 at 12:46 AM, written by RN #1, identified Resident #2 was sent to the hospital for lethargy, altered mental status, low oxygen saturation with 88-92% (normal above 90%), and heart rate was 40.</p> <p>Record review failed to identify Person #2/POA was notified of the change in condition and transfer to the hospital.</p> <p>A nursing note dated 9/2/2024 at 10:26 AM by RN #2 identified a call was placed to the hospital for a follow up on Resident #2's status, and indicated Resident #2 was admitted to the hospital with a diagnosis of pneumonia. The note further identified a call was received from Person #2, who informed RN #2 that the hospital had contacted him/her. Person #2 was informed of the hospital diagnosis and bed hold.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note dated 9/2/2024 at 3:53 PM written by RN #1 identified RN #1 received hospital report regarding Resident #2 was returning to the facility. Person #2 was notified and RN #1 explained (to Person #2) that he was the nurse that sent Resident #2 to the hospital. RN #1 apologized for the miscommunication as RN #1 believed the charge nurse alerted Person #2 regarding the transfer to the hospital as RN #1 notified the APRN on-call.</p> <p>Although attempted, interview with RN #1 was unable to be obtained during the survey.</p> <p>Interview and record review with the DON on 3/26/2025 at 2:35 PM identified RN #1 should have notified Person #2 regarding Resident #2's change in condition and transfer to the hospital. The DON stated RN #1 was the supervisor for the shift, and was responsible for ensuring the notification, but stated any staff could also have made the notification. Interview failed to identify why the POA was not notified.</p> <p>B.</p> <p>A nursing note dated 9/4/2024 at 4:20 PM by RN #3 identified Resident #2 was alert and oriented, but forgetful. Lung sounds were diminished, no cough, no shortness of breath on exertion. Follow-up chest x-ray, and Person #3 was notified.</p> <p>A nursing note dated 10/17/2024 at 2:37 PM by RN #3 identified Person #3 was updated regarding an increase in tremors and a new order for Clonazepam (used to treat anxiety and tremors), discontinued Clonazepam morning dose, and plan for a neurology appointment.</p> <p>Interview and clinical record review with DON on 3/26/2025 at 2:35 PM identified Person #2 was the POA and should be the first person to be notified of any medication changes, and not Person #3.</p> <p>Review of the facility undated Change in Condition and Change in Treatment/Services Policy directed in part, the facility must immediately notify the resident's legal representative when there is a need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the clinical record was complete and accurate to include physician/APRN notification when an ordered x-ray was delayed. The findings include:</p> <p>Resident #1's diagnoses included Alzheimer's disease, dementia, and anxiety. The Resident Care Plan (RCP) dated 2/10/2024 identified a fall risk. Interventions directed to provide assistance/supervision with mobility and toileting, and two (2) assist for transfers. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of two out of fifteen (2/15), indicative of severe cognitive impairment, and maximum assistance with two (2) persons for transfers.</p> <p>APRN #1 note dated 3/10/2025 identified Resident #1 was seen due to a fall; Resident #1 resisted transfer with assist of two (2) for a weight and fell to the floor. Complaints of left lower extremity pain, no shortening or notable deformities of the left lower extremity. Will not be sent to the hospital at this time, will monitor for pain.</p> <p>A reportable event form dated 3/10/2025 at 11:15 AM identified Resident #1 required assist of two (2) for transfers and LPN #1 observed Resident #1 fall to the floor during a transfer with assist of two to the sitting scale (to obtain a weight). Resident #1 was resistive to transfer. An order was obtained for an x-ray of the left lower extremity. A fracture was identified on 3/11/2025 at 3:15 PM.</p> <p>Nursing note dated 3/10/2025 at 12:29 PM identified one (1) hour after fall resident complained of left lower extremity pain. APRN #1 was updated and ordered left lower extremity x-rays.</p> <p>A nursing note dated 3/10/2025 at 9:25 PM (10 hours and 10 minutes after the fall), written by RN #5, identified per the Radiology Team, the x-ray will be done tomorrow due to staffing issues.</p> <p>Record review failed to identify the physician/APRN was notified the x-ray was not able to be completed until 3/11/2025 (the day after the fall).</p> <p>Nursing note dated 3/11/2025 at 10:45 AM identified knee bruised and swelling, and STAT (immediate) x-ray ordered.</p> <p>APRN #1 note dated 3/11/2025 identified bruising to the left leg, no deformities noted, knee with mild swelling and movement. X-ray result identified an acute proximal femur fracture with displacement. Will transfer to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility summary dated 3/13/2025 identified Resident #1 was alert, confused and anxious. While LPN #1 and NA #1 were transferring Resident #1 to obtain a weight, Resident #1 was resisting, LPN #1 attempted to lower Resident #1 safely to the floor and Resident #1 fell to the floor. The supervisor/RN #4 was called and assisted with transferring Resident #1 back into his/her chair. Resident #1 had positive range of motion, soreness to the left lower extremity, and an x-ray was ordered. The x-ray was performed on 3/11/2025 revealed a fracture to the left hip and Resident #1 was transferred to the hospital for evaluation.</p> <p>Interview with APRN #1 on 3/26/2025 at 1:00 PM identified on 3/10/2025 she worked until 5 or 6 PM and indicated she was not notified while she was in the facility that the x-ray was delayed for Resident #1. Further, APRN #1 identified the on-call service was not notified of the delay (the on-call service received only one call from the facility regarding another resident). APRN #1 indicated she would expect the nursing staff to update her or the physician team regarding a delay in receiving an x-ray in a timely manner.</p> <p>Interview with RN #5 on 3/26/2025 at 1:40 PM identified on 3/10/2025, she received a call from the radiology provider regarding Resident #1's x-ray and that it would not be obtained timely due to staffing issues. RN #5 indicated she notified the on-call physician team regarding the delay for the x-ray, and stated she notified the on-call about another resident issue, but she was unable to verify who on the on-call team she spoke to. RN #5 identified she should have documented in the clinical record to include that she made notification to the physician.</p> <p>Interview and clinical record review with DON on 3/26/2025 at 2:35 PM identified her expectation was that the nursing staff accurately document notifying providers in a nursing note. The DON indicated RN #5 should have written a note reflecting the call to the physician/APRN regarding the delay in obtaining the x-ray.</p> <p>Although requested, the facility did not have a policy related to documentation.</p>		