

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 06/02/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and facility documentation for three (3) of three (3) residents (Resident #1, #2, and #3) for medication administration, the facility failed to ensure residents blood glucose levels were obtained before meals and failed to ensure insulin was administered before meals according to provider order. The findings included:</p> <p>1a. Resident #1 was admitted to the facility in April of 2025 and had diagnoses that included Type 2 diabetes mellitus, dementia, and chronic obstructive pulmonary disease.</p> <p>A physician's order dated 4/23/25 directed Lispro (a short-acting insulin) administration per sliding scale (two (2) units for a blood glucose level of 151-200, four (4) units for a blood glucose level of 201-250, six (6) units for a blood glucose level of 251-300, eight (8) units for a blood glucose level of 301-350, ten (10) units for a blood glucose level of 351-400, and to notify the provider of blood glucose levels greater than 400) before meals and at bedtime for diabetes.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severe cognitive impairment (Brief Interview for Mental Status (BIMS) score of 6), was dependent with toileting, lower body dressing, and toileting transfers.</p> <p>The Resident Care Plan (RCP) dated 5/6/25 identified Resident #1 had diabetes. Interventions directed to monitor blood glucose levels and administer medications as ordered.</p> <p>Review of the mealtime schedule identified Resident #1 had breakfast scheduled for 8:00 AM, lunch scheduled for 11:30 AM, and dinner scheduled for 4:30 PM.</p> <p>The Medication Administration Report dated April 2025 identified Lispro was administered as follows:</p> <ul style="list-style-type: none"> - 4/26/25 at 10:00 AM (scheduled to be administered before breakfast) - 4/26/25 at 5:53 PM (scheduled to be administered before dinner) - 4/29/25 at 9:27 AM (was scheduled to be administered before breakfast) <p>Review of the Medication Administration Report dated May 2025 identified Lispro was administered as follows:</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - 5/1/25 at 12:05 PM (scheduled to be administered before breakfast) - 5/1/25 at 2:14 PM (scheduled to be administered before lunch) - 5/4/25 at 8:47 AM (scheduled to be administered before breakfast) - 5/4/25 at 5:31 PM (scheduled to be administered before dinner) - 5/5/25 at 9:07 AM (scheduled to be administered before breakfast) - 5/6/25 at 12:37 PM (scheduled to be administered before lunch) - 5/8/25 at 9:04 AM (scheduled to be administered before breakfast) - 5/9/25 at 8:59 AM (scheduled to be administered before breakfast) - 5/16/25 at 6:14 PM (scheduled to be administered before dinner) - 5/19/25 at 6:08 PM (scheduled to be administered before dinner) - 5/15/25, at 8:51 AM (scheduled to be administered before breakfast) - 5/16/25 at 9:07 AM (scheduled to be administered before breakfast) <p>1b. Resident #2 was admitted to the facility in April of 2025 with diagnoses that included Type 2 diabetes mellitus, chronic kidney disease, and major depressive disorder.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15) and was dependent with toileting, bathing, and mobility.</p> <p>The RCP dated 4/29/25 identified diabetes. Interventions directed to monitor blood glucose levels and administer medications as ordered.</p> <p>A physician's order dated 4/11/25 directed to administer Lispro, five (5) units, with meals for diabetes.</p> <p>Review of the mealtime schedule identified Resident #2 had breakfast scheduled for 8:00 AM, lunch scheduled for 11:30 AM, and dinner scheduled for 4:30 PM.</p> <p>Review of the April Medication Administration Report identified Lispro was to be given at 8:00 AM, 12:00 PM, and 5:00 PM with meals, however, was administered as follows:</p> <ul style="list-style-type: none"> - 5/1/25: 5 units were administered at 10:36 AM - 5/6/25: 5 units were administered at 9:27 AM - 5/7/25: 5 units were administered at 6:04 PM <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 5/8/25: 5 units were administered at 9:16 AM</p> <p>- 5/15/25: 5 units were administered at 9:24 AM</p> <p>- 5/20/25: 5 units were administered at 9:15 AM</p> <p>- 5/21/25: 5 units were administered at 7:11 PM</p> <p>- 5/23/25: 5 units were administered at 9:17 AM</p> <p>- 5/28/25: 5 units were administered at 6:06 PM</p> <p>- 5/30/25: 5 units were administered at 6:33 PM</p> <p>- 5/31/25: 5 units were administered at 7:07 PM</p> <p>- 6/1/25: 5 units were administered at 6:24 PM</p> <p>1c. Resident #3 was admitted to the facility in February of 2023 and had diagnoses that included Type 2 diabetes mellitus, dementia, and anxiety disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had severe cognitive impairment (Brief Interview for Mental Status (BIMS) score of 7) and required substantial assistance with toileting, bathing, and personal hygiene.</p> <p>The RCP dated 5/6/25 identified risk for hyper/hypoglycemia related to diabetes mellitus, type 2. Interventions directed to monitor blood glucose levels per physician's order and administration of insulin per order.</p> <p>A physician's order directed to administer Insulin Lispro Injection Solution 100 units per milliliter as per sliding scale: (two (2) units for a blood glucose level of 200-249, three (3) units for a blood glucose level of 250-299, four (4) units for a blood glucose level of 300-349, five (5) units for a blood glucose level of 350-399, six (6) units for a blood glucose level of greater than 400 and provider notification) with meals related to Type 2 diabetes mellitus with diabetic neuropathy.</p> <p>Review of the mealtime schedule identified Resident #3 had breakfast scheduled for 8:30 AM to 8:45 AM, lunch scheduled for 12:00 PM to 12:15 PM, and dinner scheduled for 4:30 PM to 4:45 PM.</p> <p>Review of the April Medication Administration Report identified Lispro was to be given at 8:00 AM, 12:00 PM, and 5:00 PM with meals, however, was administered as follows:</p> <p>- 5/7/25: at 5:56 PM (scheduled to be administered with dinner)</p> <p>- 5/12/25: at 6:06 PM (scheduled to be administered with dinner)</p> <p>- 5/14/25: at 11:01 AM (scheduled to be administered with lunch)</p> <p>- 5/14/25: at 5:54 PM (scheduled to be administered with dinner)</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - 5/15/25: at 9:09 AM (scheduled to be administered with breakfast) - 5/19/25: at 1:10 PM (scheduled to be administered with lunch) - 5/21/25: at 6:08 PM (scheduled to be administered with dinner) - 5/22/25: at 1:00 PM (scheduled to be administered with lunch) - 5/25/25: at 1:02 PM (scheduled to be administered with lunch) - 5/24/25: at 5:20 PM (scheduled to be administered with dinner) - 5/28/25: at 7:05 PM (scheduled to be administered with dinner) - 5/30/25: at 6:32 PM (scheduled to be administered with dinner) - 5/31/25: at 6:39 PM (scheduled to be administered with dinner) - 6/1/25: at 6:23 PM (scheduled to be administered with dinner) <p>Interview with RN #1 on 6/2/25 at identified meals were served to residents anytime between their scheduled mealtime and thirty (30) minutes thereafter.</p> <p>Interview with the Director of Nursing Services (DNS) on 6/2/25 at 1:10 PM identified the facility's standard of practice was to check the resident's blood glucose level prior to meals.</p> <p>Interview with APRN #1 on 6/2/25 at 12:39 PM identified staff should obtain blood glucose levels within thirty (30) minutes of meal intake. APRN #1 later identified that a resident could be at risk for a hypoglycemic episode if blood glucose levels were taken during or following meals, depending on how much food was eaten prior to the blood glucose level being checked and treated.</p> <p>Interview with the DNS on 6/3/25 at 1:41 PM identified residents prescribed a set dose of insulin with meals should be administered their dose either thirty (30) minutes prior to their meal or with their meal.</p> <p>Review of the Medication Administration and General Guidelines policy directed medications were administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The policy further identified that medications were administered in accordance with written orders of the prescriber.</p>		