STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record and policy review for 1 of 3 residents (Resident #40) sampled for nutrition, the facility failed to include a resident in the participation of the development and implementation of his or her person-centered plan of care. The findings include: Resident #40 was admitted to the facility in April 2025 with diagnoses that included dysphagia, aphasia, and Type 2 diabetes mellitus. The baseline Resident Care Plan (RCP) dated 4/19/25 identified Resident#40 had a decline in intellectual functioning characterized by a deficit in memory, judgement, decision making and thought process related to altered mental status. The facility admission Record Face Sheet dated 4/19/25 identified Resident #40 was the guarantor and care conference person and Person #1 was an alternate care conference contact. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 was severely cognitively impaired and required substantial/maximal assistance with eating, oral hygiene, and dressing. Additionally, the MDS identified Resident #40 was an active participant in the assessment process and goal setting, with an overall goal to return to the community. Although multiple requests were made, the facility failed to identify if any person (Resident #40 or Person #1) was invited and/or attended the RCC, and could not identify who from the interdisciplinary team attended the RCC, either through a RCC attendance sheet or social service notes, etc. Interview with the Regional Registered Nurse (RN) #6 on 5/13/25 at 12:30 PM identified the facility did not have a RCC sign in sheet for Resident #40 because a conference was not held. Additionally, he identified that a conference should have been held, and it was the responsibility of the MDS Coordinator and Social Services to ensure the meeting took place. Interview and record review with the MDS Coordinator Registered Nurse (RN) #5 on 5/13/25 at 12:42 PM identified it was facility policy to hold a RCC with the resident or responsible party 48-72 hours after admission, and then quarterly. The record review failed to identify social worker or MDS documentation that the meeting was held, or that Resident #40 was invited to attend. Additionally, she identified it was the social workers responsibility to schedule the conference and invite the resident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075393	A. Building B. Wing	05/13/2025

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F 0553 Level of Harm - Potential for minimal harm Residents Affected - Some	The social worker was not available for interview. Review of the Care Planning Policy identified the care plan is developed by the interdisciplinary team in collaboration with the resident and/or the responsible party and the resident's physician. The resident or responsible party will be invited to attend all care plan conferences.

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	075393	A. Building B. Wing	05/13/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for one of four residents (Resident #24) reviewed for pressure ulcers and one out of three residents (Resident #40) reviewed for nutrition, the facility failed to notify the Advanced Practice Registered Nurse (APRN) and family/responsible party of a significant weight loss. The findings include: 1. Resident #24 had diagnoses that included dysphagia, the presence of a cardiac pacemaker and dementia. The Resident Care Plan (RCP) dated 1/16/25 identified Resident #24 had a history of pressure wounds and was at risk for oral/nutritional problems with a goal to not have a weight loss. Interventions included weight as ordered and per facility protocol, and Registered Dietician (RD) evaluation as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 was severely cognitively impaired, required substantial/maximal assistance with for eating and was dependent for personal hygiene and transfer. Review of Resident #24's weights in the clinical record identified weights were as follows: on 3/22/25 Resident #24 weighed 118 pounds (lbs.), on 3/29/25 weighed 116.3 lbs., on 4/5/25 weighed 115.8 lbs., and on 4/19/25 weighed 106.1 lbs. (a 11.9 lb./10.08% loss in 28 days). The next recorded weight on 4/24/25 was a re-weight of 104.1 lbs (a continued weight loss of 13.9 lbs./11.77% in 33 days). A Dietician note dated 4/28/25 (9 days after the significant weight loss was documented and 4 days after the re-weight) at 1:19 PM identified Resident #25 weight monitoring identified weight of 118 lbs. to 106/104 lbs. this morning. Severe weight loss of 10.5%. Intake had declined to 50-75% of meals. Resident #24 received assistance with meals and was consuming supplements every day 75- 100%. Plan was to increase supplements to address unplanned weight loss. Nursing notes failed to identify documentation that the APRN or family had been updated about the loss of 11.9 lbs. or 10.08 percent (%) of body weight in less than 1 month. As well as after a reweight that was completed on 4/24/25 of 104.1 that confirmed the weight loss. Interview with RN #1, (the 7:00 AM to 3:00 PM Nursing Supervisor) on 5/9/25 at 8:20 AM identified that if a resident had a confirmed significant weight loss identified by nursing, they would contact the nursing supervisor who would then contact the APRN and family. The weight loss would be confirmed by a reweight. The nursing staff would also contact the dietician either face to face when she was here, place information in her communication book or email her. Although she was not on 4/19/25, she was the Nursing Supervisor on 4/24/25 and could not recall that she was contacted with Resident #24's confirmation re-weight. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of Resident #24's medical record with APRN #2 on 5/9/25 at 10:52 AM identified she was unaware of Resident #24's significant weight loss initially recorded on 4/19/25 or when the reweight was completed on 4/23/25. She would have expected the nurses to contact her or at least place the information in the APRN communication book located on the unit. She just reviewed the book and noted that there was no documentation of Resident #24's weight loss. Had she been contacted on 4/19/25 or 4/23/2025 she would have evaluated the resident, documented her evaluation and would have likely started the additional supplements that were ordered upon notification of the significant weight loss on 4/28/25. Interview and review of Resident #24's medical record with the Director of Nursing (DNS) on 5/12/25 at 8:40 AM identified that she would expect the nursing staff to contact the APRN for a significant weight loss of 5%. She continued that it would also be placed in the APRN follow up book. She did not know the reason this was not done when Resident #24 had the documented 10.08% weight loss in 1 month on 4/19/25 and after the next weight, recorded on 4/24/25. The nursing staff should also contact the family to notify them of the weight loss at the time it was identified. Interview and review of Resident #24's medical record with the Dietician on 5/12/24 at 9:40 AM identified she had reviewed Resident #24's record on 4/16/25 and had added a supplement due to Resident #24's reported decreased meal intake. Upon her review the next time she was at the facility on 4/23/25, she identified the 4/19/25 recorded weight of 106.1 lbs. She noted that the electronic medical record had flagged the weight as a 10.5% weight loss for Resident #24 from the previous month's recorded weight on 3/22/25 of 118 lbs. She continued that she did not evaluate Resident 24's flagged unplanned significant weight loss on 4/23/25 as she needed to have a confirmed weight with a reweight before completing an evaluation. She placed a request into Resident #24's electronic record (PCC) for a reweight but did not talk to nursing to get a reweight that day. She continued that it was the end of day and that was the most efficient way for her to communicate the need for a reweight as it would populate a report that the facility would review and assure the request was completed. When she returned to the facility on 4/28/25, she noted that the reweight documented for Resident #24 was completed on 4/24/28 as 104 lbs. With the reweigh completed, she determined the weight to be accurate and she completed her evaluation with recommendations for increased supplements. She then triggered in PCC that the information be placed on the MD report that the APRN would review. She had not contacted the APRN prior to notifying through PCC on 4/28/25. Interview with LPN #3 and review of Resident #24's weight documentation on 5/13/25 at 11:00 AM identified she recorded Resident #24's weight on 4/19/25 of 106 lbs. and did not know the reason she did not reweigh the resident at that time and she did not know why she did not contact the supervisor or the APRN. She continued that she 'had dropped the ball. Had she contacted the supervisor, either she or the supervisor would have contacted the family. She identified she also should have sent an email or written in the dietician's communication book to notify the dietician as well. She did not do that either. Subsequent to the surveyor inquiry, APRN #2 evaluated Resident #24's weight loss on 5/9/25 and agreed with the current treatment plan as recommended by the Dietician and to monitor. 2. Resident #40 was admitted to the facility in April 2025 with diagnoses that included dysphagia, aphasia, and Type 2 diabetes mellitus. A physician's order dated 4/21/25 directed to weigh Resident #40 weekly on shower days. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated 4/23/25 identified Resident #40 had impaired utilization of nutrients related to diabetes mellitus, stroke, no teeth, and being on a puree diet. Other impaired utilization of nutrients listed were elevated blood pressure with the risk for weight loss and unplanned weight loss, muscle loss related to diet texture dislike and refusing to eat puree meats. Interventions included to provide diet and fluids as ordered, magic cup supplement with lunch, weights as ordered per facility protocol, Registered Dietician evaluation as needed, speech therapy as needed, monitor dietary intake as ordered, and administer supplements as ordered. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 was severely cognitively impaired and required substantial/maximal assistance with eating, oral hygiene, and dressing. Additionally, the MDS identified Resident #40's weight on admission was 144 pounds, without loss of liquids/solids from mouth when eating/drinking, holding food in mouth/cheeks or residual food in mouth after meals, coughing/choking during meals or when swallowing medications, or complaints of difficulty/pain when swallowing. Although physician's orders directed to weigh Resident #40 weekly on shower days, a review of the weights and vitals sheet identified weekly weights were only taken on 4/19/25 (144.2 pounds), and on 5/5/25, (123.4 pounds). (Identifying a significant weight loss of 20.8 pounds/14.4 % in 2 weeks). A physician's order dated 5/7/25 that was entered by the Dietician and not from MD/APRN being notified per interview with the Dietician on 5/9/25 at 11:36 AM directed for a re-weight on 5/7/25 to verify the weight loss of 20.8 pounds in 2 weeks. A review of Resident #40's electronic health record failed to identify the APRN/physician was notified of the significant weight loss. Interview and record review with Registered Nurse (RN) #1 on 5/9/25 at 9:55 AM identified it was facility policy to obtain a reweight for a significant/severe weight loss, update the family, provider and Dietician. The record review failed to identify that the provider was notified of the weight loss. Interview with APRN #2 on 5/9/25 at 10:02 AM failed to identify that she was notified of Resident #40's severe weight loss, but stated the facility had another APRN that also oversees Resident #40. Interview with APRN #1 on 5/9/25 at 10:22 AM identified she was not aware of the severe weight loss for Resident #40, only speech therapy and family concerns of poor meal intake for which she started him/her on an appetite stimulant. If she had been notified of the severe weight loss, she would have collaborated with speech therapy and the Dietician to find out the underlying cause, order blood work, and make sure it's not due to any medications he/she was on. Review of the Resident Nutrition Services Policy directed in part that nursing personnel will evaluate food and fluid intake in residents with, or at risk for, significant nutritional problems. Significant variants from usual eating or intake patterns must be recorded in the resident's medical record. The nurse supervisor shall evaluate the significance of such information and report it to the attending Physician and Dietician. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Weight Assessment and Intervention, directed in part that any weight change of 5 % or more since the last weight assessment will be retaken the next day for confirmation with nursing communicating the weight in writing to the dietician once verified. The dietician will respond within 48 hours of the written receipt. The threshold for significant unplanned weight loss was a 5% weight loss in 1 month with a loss greater than 5% was considered severe.

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	075393	A. Building B. Wing	05/13/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #25) reviewed for grievances, the facility failed to notify state and local authorities of an allegation of neglect. The findings include: Resident #25 was admitted with diagnoses that included cancer that spread to the bone, major depression and post-traumatic stress syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 was alert and oriented and was independent for personal hygiene, ambulation with a walker and transfer. The Resident Care Plan (RCP) dated 3/25/25 identified Resident #25 had a history of anxiety and depression. Interventions included observing for periods of anxiety or sadness, provide a calm, quiet environment and encourage Resident #25 to verbalize thoughts and feelings related to anxiety. A facility grievance/concern form dated 4/15/25, noted Resident #25 reported that a call bell was ringing in another resident's room at 1:00 AM. Resident #25 went to the nurse's station and observed the Licensed Practical Nurse (LPN) #5 to be sleeping. She/he called out to LPN #5, but LPN #5 did not wake up. Resident #25 took a picture of LPN #5 and sent it to the Director of Nurses (DNS) later in the shift at 4:27 AM, the concern form continued that Resident #25 noticed the same call light was on reporting that the staff did not answer the call light. Resident #25 continued that it was not answered until her/his nurse, after finishing medication administration at 5:14 AM, answered it. Resident #25 expressed that the facility was lucky as the other resident could have fallen or had a medical emergency. At 7:15 AM, Resident #25 reported that she/he had overheard the day shift NAs saying that 2 residents on the unit had not been changed overnight due to the call bell not answered for 3 hours. A facility statement dated 4/15/25 and written by Nurse Aide (NA) #3 identified she had found Resident #32 with a saturated brief and pad. Resident #32 reported that staff did not provide her/him with any care overnight. A Grievance response letter dated 4/22/25 addressed to Resident #25 written by the Director of Social Work identified that the findings of the investigation into staff sleeping was confirmed. The findings regarding Resident #25's report of incontinent care not being completed was not confirmed. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

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Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the facility investigation of Resident #25's 4/15/25 allegation with the Director of Nursing (DNS) on 5/12/2025 at 8:40 AM identified if there was a report of a resident who did not get care for overnight or for 3 hours, she would consider it an allegation of neglect. She continued that she completed the investigation into Resident #25's grievance and addressed both reported concerns as documented on the grievance form: sleeping staff, unanswered call bell, and staff not checking or changing residents. She confirmed that the LPN was asleep and as part of Resident #25's grievance investigation, she completed a call bell and incontinence care audit. Reviewing NA #3's statement, she identified that it could be interpreted as an allegation of neglect. The DNS was aware of the reporting requirements for allegations of neglect and identified that she did not report the allegation of the staff not providing incontinence care as she only followed the facility's grievance process when completing the investigation. Interview and review of a facility statement dated 4/15/25 with NA #3 on 5/12/25 at 11:55 AM identified she was working on 4/15/25 on Resident #25's unit. Resident #32 had the call light on when she came on shift at 7:00 AM and she went to the room to see what was needed. Resident #32's pad and incontinent brief were saturated, and Resident # 32 had reported that she/he had not been changed all night. She immediately went to get RN #1, the supervisor to evaluate the resident. Interview with RN #1 on 5/12/25 at 1:14 PM identified that on 4/15/25, NA #3 came to her early in the shift to report that Resident #32 reported that she/he did not get changed overnight and NA #3 asked her to come to the resident's room. Resident #32 identified that she/he had not been changed all night. RN #1 assisted NA #3 to change the resident. RN #1 recalled Resident #32's pad and incontinent brief were saturated with urine. She immediately reported it to the Director of Nurses as she felt it was an allegation of neglect. The Director of Social Work was unavailable for interview during the survey. The facility policy Recognizing Signs and Symptoms of Abuse/Neglect/Exploitation or Mistreatment dated 11/25/2016 identified in part, that signs of possible physical neglect included caregivers' intentional indifference to resident's personal care or needs or residents left alone who needed supervision. The facility policy Reporting Abuse to Facility Management dated 11/25/2016 directed in part, when an alleged abuse is reported, the administrator or designee notified the following persons or agencies: the state DPH, attending physician, responsible party and the local police. Abuse was defined as deprivation by an individual including the caretaker, of services necessary to attain or maintain physical, mental and psychosocial well-being. Neglect was defined as the failure to provide goods and or services to the resident to avoid physical harm, pain, mental anguish or emotional distress. Any individual observing or suspecting resident abuse must promptly report the incident and a reportable event form is completed.

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	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility policy and staff interviews for 1 of 5 sampled residents (Resident #25) reviewed for Pre-admission Screening and Resident Review (PASRR), the facility failed to ensure a Level 1 pre-screen of a new resident with a mental disorder diagnosis was completed. The findings included: Resident #25 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, anxiety disorder, and post-traumatic stress disorder. A Preadmission Screening and Resident Review (PASRR) Level 1 Screen outcome dated 6/7/16 and from a previous long term care stay at another facility (completed by the State contracted agency for PASRR review) identified Resident #25 had no level 2 condition and that the PASRR Level 1 was negative. Review of the notice of action letter dated 6/15/17 identified that Resident #25's PASRR Level 1 screening was reviewed by the State contracted agency and showed that nursing facility placement was appropriate. Additionally, it identified that no further Level 1 screening was needed unless Resident #25 had or was suspected of having a serious mental illness or an intellectual or developmental disability and exhibit a significant change in treatment needs. The Resident Care Plan (RCP) dated 1/15/24 identified a problem with depression with interventions that included medications as ordered, allow resident to verbalize feelings concerning disease process, encourage resident to participate in activities of choice, and MD to evaluate drug regimen. Additional interventions included psychiatry consult/follow-up, and during episodes of sadness, encourage resident to discuss feelings. Additionally, the RCP identified a problem with anxiety and interventions included to monitor periods of anxiety, help resident identify events that have precipitated anxiety in the past, encourage verbalizing thoughts and feelings to external anxiety, attempt to redirect resident's focus to the present situation, provide calm and quiet environment, psychiatry evaluation and follow-up, and to administer anti-anxiety per order and monitor for effectiveness. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 was cognitively intact and had active diagnoses of anxiety disorder, depression, and post-traumatic stress disorder. Review of the clinical record and interview with the Administrator on 5/13/25 at 8:05 AM identified Resident #25 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder, anxiety disorder, and post-traumatic stress disorder and identified a negative PASRR Level 1 screening dated 6/7/16. Additionally, the interview identified that if a new admission had a previous PASRR Level 1 screen, it was received by the facility from the discharging facility, and reviewed by the social worker (SW) with follow-up as necessary. Additionally, the Administrator indicated it was the responsibility of the social worker to review and submit to the proper agency for any significant changes. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview and clinical record review with SW #1 on 5/13/25 at 11:05 AM identified that the facility received PASRR outcomes from the facility where the resident was being discharged from. SW #1 identified Resident #25 had a negative PASRR Level 1 screen dated 6/7/16 on facility admission, with no mental disorders noted. SW #1 stated that it was the social service departments responsibility to review PASRR's on admission and that a resident with a negative PASRR Level 1 screen who was admitted with mental disorders should have had the State contracted agency conduct a new PASRR Level 1 screen. The interview failed to identify the reason a new Level 1 screen was not completed upon admission to the facility. Review of the contracted State agency PASRR and level of care screening and procedures for long term care services manual identified that a person with known or suspected serious mental illness who is requesting admission to a Medicaid Certified nursing facility must be evaluated through the PASRR process.

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	075393	A. Building B. Wing	05/13/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, observations, review of the clinical record and facility policy for 1 of 5 sampled resident (Resident #5) reviewed for side rails and for 1 of 3 sampled residents (Resident #53) reviewed for pressure ulcers, the facility failed to ensure the Resident Care Plan (RCP) was comprehensive to include side rail padding (Resident #5) and refusals for positioning (Resident #53). The findings include: 1. Resident #5's diagnoses included vascular dementia without behavioral disturbances, generalized muscle weakness and cachexia (irreversible weight and muscle loss). A physician's order dated 11/9/20 and currently in effect directed for quarter (¼) side-rails to be in place to both sides of the bed for mobility and transfer ability. A side rail evaluation dated 3/2/23 identified that a side-rail was indicated for enhancement of mobility and that the resident expressed a desire for a side-rail. It reported that side-rails were not indicated to provide safety for Resident #5 and that the resident does not have a history of seizures. The evaluation did not identify how many side-rails were indicated or the length of the side-rails that were to be put in place. A side rail evaluation dated 8/18/23 was incomplete with no information filled out. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was severely cognitively impaired and required substantial assistance for bed mobility. The Resident Care Plan (RCP) dated 2/18/25 identified that Resident #5 was at risk for falls related to decreased strength, decreased coordination, impaired sense of balance and unsteady gait (walking or moving on foot). Interventions included providing assistance with all Activities of Daily Living (ADLs). Observation of Resident #5 on 5/8/25 at 10:58 AM identified Resident #5 in bed with double-sided Velcro pads intact to both side-rails. Observation of Resident #5 on 5/9/25 at 12:51 PM identified Resident #5 in bed with double-sided Velcro pads intact to both side-rails. Review of active physician's orders and/or the RCP failed to identify the use of side-rail padding. Review of the Nurse Aide Care Card (undated) failed to identify the use of ¼ side rails or side rail padding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #5 and interview with the DNS on 5/9/25 at 2:35 PM identified the resident in bed with double-sided Velcro pads intact to both side-rails, reporting that she was unsure of the reason the padding was in place, that the use of side-rail padding should be identified in the RCP and she was unsure of the reason it was not. She reported that she was unaware that side-rail padding was not identified on the facility paper care cards for the Nurse Aides (NA's) to also follow. The DNS identified that she was unable to provide documentation as to the reason the padding was in place. 2. Resident #53's diagnoses included type 2 diabetes mellitus with hyperglycemia, chronic pain and edema. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #53 was moderately cognitively impaired, required substantial assistance for bed mobility and was dependent on staff for transfers. The Resident Care Plan (RCP) dated 4/8/25 identified that Resident #53 was at risk for skin breakdown due to immobility and deconditioning and had recurrent skin breakdown on the sacrum/coccyx. Interventions included turning and repositioning the resident every 2 hours while in bed and as it meets the resident's needs, pressure redistribution devices as ordered, following the facility skin protocol and reporting any new areas to the nurse and provider. Review of wound care physician's note dated 5/2/25 identified that Resident #53 was seen for evaluation of a Moisture Associated Skin Damage (MASD) wound which measured 2.0 centimeters (cm) by 1.5 cm by 0.2 cm reporting that the wound base was 100 percent (%) granulation (newly formed connective tissue indicating the start of the healing process) and a moderate amount of serous drainage (clear, thin, watery fluid seen in the early stages of wound healing) was noted. The note identified that the wound had been first evaluated on 3/28/25 and that a pressure redistributing mattress was in place, staff was repositioning the resident every 2 hours and that staff was encouraging an out of bed schedule. Observation of Resident #53 with Registered Nurse #3 (wound nurse) and MD #2 (wound physician) on 5/9/25 at 11:00 AM identified Resident #53 lying on his/her back without offloading with the head of the bed elevated approximately 45 degrees, an air mattress was in place to the bed, and the resident's spouse was at the bedside. The coccyx wound was assessed by MD #2 and was measured at 3 cm by 1.5 cm, Medi honey (wound treatment) was applied to the wound bed and a foam dressing was applied. All infection control measures were noted to be followed. A pillow was then placed under the resident's left buttocks for offloading purposes. Interview with MD #2 on 5/9/25 following the wound evaluation identified that although the resident was receiving a protein supplement and staff was attempting to offload and reposition Resident #53 off of his/her coccyx area frequently, he reported that the coccyx wound had worsened to a Stage 3 pressure ulcer (full-thickness skin loss where the wound extends through the skin and into the subcutaneous tissue revealing the fatty layer). MD #2 stated that the worsened wound was due to the resident's non-compliance with repositioning, not allowing the head of the bed to be lowered to offload pressure to his/her lower back and buttocks and refusing a consistent out of bed schedule. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound care physician's note dated 5/9/25 identified that Resident #53 was seen for evaluation of a coccyx wound which measured 3.0 centimeters (cm) by 1.5 cm by 0.2 cm reporting that the wound base was 100 percent (%) granulation and a moderate amount of serous drainage was noted. The note identified that the wound was now a Stage 3 pressure ulcer and that despite the facility treating the wound correctly, the resident's co-morbidities (multiple diagnoses) and his/her unwillingness to offload the area is contributing to the outcome/decline. Interview and review of Resident #53's Care Plan (RCP) with RN #3 on 5/9/25 at 11:32 AM identified that although he was aware that Resident #53 doesn't allow staff to consistently turn and reposition him/her. Additionally, RN #3 stated Resident #53 would only allow repositioning onto the left side, would often complain of the pillow on one side of his/her buttocks and request that it be pulled out, he was unsure of the reason the RCP did not include Resident #53's refusals, stating Resident #53 should have been, as the refusals have been taking place for a few months. RN #3 reported that although he made rounds with the wound physician and received updates prior to other staff related to skin integrity, it was the responsibility of the charge nurse, MDS or Nursing Supervisor to update the plan of care to include refusals. Interview with NA #1 on 5/9/25 at 12:12 PM identified that when Resident #53 was in bed, he/she often refused to allow the head of the bed to be lowered and to be repositioned and when he/she does allow it, the resident often requested for the pillow to be removed shortly after. NA #1 reported that when Resident #53 doesn't allow repositioning, she sometimes reports it to the charge nurse if they were in the area. Subsequent to surveyor inquiry, Resident #53's RCP related to skin breakdown was updated on both 5/9/25 and 5/11/25 to identify that he/she refused repositioning, offloading and an out of bed schedule. Interview with RN #5 (MDS Coordinator) on 5/12/25 at 10:10 AM identified that although she only began employment at the facility 1 week ago, refusal care plans were an interdisciplinary responsibility, stating that staff that observed a behavior consistently should be the ones to update the plan of care, identifying that she updated the RCP's when she was reviewing resident documentation for quarterly evaluations but that initiation of behavior care plans to include resident refusals were not her sole responsibility. Review of the Care Planning- Interdisciplinary Team policy (undated) directed, in part, that ongoing changes in residents' status shall be updated by Nursing and/or Interdisciplinary Team (IDT) as needed. As care plans are updated, staff shall follow the updated plan of care and as updated on the Care card as applicable. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family.

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	075393	A. Building B. Wing	05/13/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #23) reviewed for medication administration, the facility failed to ensure that the expiration date was checked on a narcotic medication prior to administration. The findings include: Resident #23's diagnoses included Parkinson's disease, chronic pain and type 2 diabetes mellitus with polyneuropathy. A physician's order dated 3/20/25 directed to administer Morphine Sulfate Extended Release (ER) 15 milligram (mg) oral tablet by mouth every eight (8) hours for chronic pain, as part of a 45 mg dose (received in combination with a 30 mg tablet) and to hold for sedation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 had intact cognition and was independent with eating, personal care and bed mobility. The Resident Care Plan (RCP) dated 4/10/25 identified Resident #23 had pain related to cancer, a history of chronic pain and was receiving Morphine and Dilaudid (narcotic pain medications) for break-through pain. Interventions included assessing the characteristic of the pain, reassessing interventions with any changes in response to pain or pain medications and with every assessment and administering pain medications as ordered. Review and observation of the Annex medication cart narcotic box on 5/9/25 at 12:55 PM with LPN #1 identified one (1) blister pack of Morphine Sulfate Extended Release (ER) 15 mg oral tablets with prescription number 2910659/001. The blister pack was noted to have seven (7) tablets remaining and had a lot number A71434 and an expiration date of 3/19/25. Review of the Controlled Substance Disposition Record for the Morphine Sulfate Extended Release (ER) 15 mg oral tablet with prescription number 2910659/001 identified that it was sent by the pharmacy and received on 4/4/25 (16-days after expiration) with sixty (60) tablets. The disposition record identified that fifty-three (53) tablets had been signed out as administered between 4/15/25 and 5/2/25 (after the medication's expiration date). Interview with LPN #1 on 5/9/25 at 12:55 PM identified that he had signed out the Morphine on 4/21/25 at 5:52 PM and on 4/25/25 at 9:40 AM from that blister pack (prescription number 2910659/001), reporting he didn't check the expiration date and never noticed the medication had expired but identified that he should always check for expiration dates prior to medication administration. The DNS was subsequently notified. Interview with the DNS on 5/9/25 at 1:50 PM identified that she contacted the pharmacy and they stated that the expiration date on the blister pack of Morphine Sulfate Extended Release (ER) 15 mg oral tablet with prescription number 2910659/001 was incorrect and that the correct expiration date was 10/26, reporting that the pharmacy stated they would fax a confirmation letter and pick up the medication from the facility. The DNS identified that it was her expectation that all staff check the expiration date on all medications prior to administering the medication to a resident and reported that she was unsure why this hadn't happened for Resident #23's Morphine Sulfate Extended Release (ER) 15 mg oral tablet with prescription number 2910659/001. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a pharmacy fax dated 5/9/25 regarding Resident #23 identified that they had spoken with the facility DNS about the Morphine Sulfate 15 mg ER tablets with an expiration of 2025 reporting that they checked the lot number and stock bottle, and the foil had been misprinted and the actual expiration was 10/2026. It identified that they would pick up the medication from the facility and fix the foil. Review of the Medication Storage in the Facility policy (undated) directed, in part, that the nurse will check the expiration date of each medication prior to administering it. No expired medications will be administered to a resident.

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	075393	A. Building B. Wing	05/13/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record and policy review for 1 of 3 residents (Resident #40) sampled for nutrition, the facility failed to follow a physician's order to obtain weekly weights and a reweight on a resident with a significant weight loss. The findings included: Resident #40 was admitted to the facility in April 2025 with diagnoses that included dysphagia, aphasia, and type 2 diabetes mellitus. A physician's order dated 4/21/25 directed to weigh Resident #40 weekly on his/her shower day. The Resident Care Plan dated 4/23/25 identified Resident #40 had impaired utilization of nutrients related to diabetes mellitus, stroke, no teeth, puree diet, and elevated blood pressure with risk for weight loss and unplanned weight loss, muscle loss related to diet texture dislike and refusing to eat puree meats. Interventions included diet and fluids as ordered, magic cup supplement with lunch, weights as ordered per facility protocol, registered dietician evaluation as needed, speech therapy as needed, monitor dietary intake as ordered, and administer supplements as ordered. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 was severely cognitively impaired and required substantial/maximal assistance with eating, and oral hygiene. Additionally, the MDS identified Resident #40's weight on admission was 144 pounds, without loss of liquids/solids from mouth when eating/drinking, holding food in mouth/cheeks or residual food in mouth after meals, coughing/choking during meals or when swallowing medications, or complaints of difficulty/pain when swallowing. Although physician's orders directed to weigh Resident #40 weekly on shower day, a review of the weights and vitals sheet identified weekly weights were only taken on 4/19/25 (144.2 pounds), and on 5/5/25, (123.4 pounds). (A severe weight loss of 20.8 pounds/14.4 % in 2 weeks). A physician's order dated 5/7/25 directed for a re-weight on 5/7/25 to verify the weight loss from 5/5/25 of 20. 8 pounds in 2 weeks. Although physician's orders directed to reweigh Resident #40 on 5/7/25, a review of the weights and vitals sheet identified Resident #40 was not reweighed. Interview with Nurse Aide (NA) #1 on 5/9/25 at 8:58 AM identified the NA's were notified by the nurse to weight and resident and the NAs were responsible for obtaining resident weights , and the weights were documented on the vital sign clipboard. Interview and record review with Registered Nurse (RN) #1 on 5/9/25 at 9:55 AM identified it was facility policy to obtain weights on residents per physician or dietician order, that the NAs were responsible for obtaining the weight and the nurse checks for completion/discrepancies and then transcribes the weight from the vital sign sheet into the electronic health record. Review of the weights with RN #1 failed to identify that weights were obtained weekly per physician's order or that a reweight was obtained on 5/7/25, with the only weights documented were on 4/19/25 (admission) and 5/5/25. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, RN #1 obtained a re-weight for Resident #40, which was documented as 132.6 pounds. Review of the Weight Assessment and Intervention Policy directed in part for nursing staff to obtain resident weight on admission, the next day and weekly for 4 weeks. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month-5% weight loss is significant; great than 5% is severe. Interventions for undesirable weight loss shall be based on careful consideration of the following: resident choices, nutrition and hydration needs, functional factors, environmental factors, chewing or swallowing abnormalities, medications, use of supplementation or feeding tubes and end of life decisions.

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	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, facility policy and interviews, the facility failed to ensure the medication carts and medication storage room were free from unlabeled and expired medications and non-medication items and that medications were stored properly. The findings include: 1. Observation and interview on 5/9/25 at 11:38 AM in the South Wing Medication room with the DNS, identified house stock medications including a box of 100 capsules of Diphenhydramine (an antihistamine and/or sedative medication) 25 milligram (mg) expired 11/2024, and a box of Beneprotein 0.25 ounce packets expired 7/2023. Opened, unlabeled and undated medications were identified as Miconazole Nitrate 2 percent (%) cream and Lactulose (a medication used as a laxative or to treat liver disease) 10 grams (g) in 15 milliliters (mL) solution. Food items were observed to be stored in the medication room cabinets alongside house stock medications included a basket of coffee creamers and sugar/sugar substitute packets, and a foam take out container with plastic utensils inside. Drawers of the medication room were contained of unlabeled curling irons, electric razors, charging cords, headphones, air pumps, glasses and hearing aids. The DNS identified that expired medications, opened and unlabeled medications, food items, electronics and residents' personal items should not be stored in the medication room, and she was unsure of the reason the above medications were present and not discarded. She identified that expired and discontinued medications should be stored in the applicable bin to be returned to the pharmacy and not in the cabinets, drawers or the countertops of the medication room. The DNS identified that all food items should be stored in the nourishment room only. She reported that the South Wing medication room was recently cleaned out approximately one (1) week ago and was completed every week on the day shift and was unsure of the reason staff were storing the above items in the medication room. 2. Observation of the nursing supervisor's office and interview with RN #1 (the 7:00 AM to 3:00 PM nursing supervisor) on 5/9/25 at 12:42 PM identified a box of Juven packets (a powder that is mixed with water and ingested to support wound healing) and a box of fourteen (14) bottles of Kayexalate (a medication to treat elevated potassium levels) 15 grams on the top shelf above the desk. RN #1 reported that she was unsure of the reason the Juven packets were in the nursing supervisor's office, stating they should have been in the medication room but identified that the bottles of Kayexalate 15 grams were stock for the Pyxis (automatic medication dispensing team). She reported that the bottles do not fit in the drawers of the Pyxis and she hadn't had time to call the pharmacy and decide how to get a larger drawer added but identified that they shouldn't have been stored in the nursing supervisor's office. 3. Observation and interview on 5/9/25 at 12:55 PM with LPN #1 of the Annex medication cart, identified an opened, unlabeled and undated container of Xarelto (a medication to prevent blood clots) 15 mg tablets with an expiration date of 4/2025 and nine (9) house stock Diphenhydramine capsules in a blister pack with an expiration date of 3/2024. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple loose pills totaling at least ten (10) were noted in and around the blister packs of the medication cart. The bottom drawer of the medication cart was noted with a roller hairbrush, unlabeled black glasses, nine (9) loose green lancets, an open package of Calcium Alginate (wound treatment product) and multiple packets of Peri- Guard ointment (skin protectant). LPN #1 identified that expired medications should not be stored in the medication cart, reported that non medication items such as treatment items, hairbrushes and unlabeled personal items should not be stored in the medication cart, and he was not sure of the reason the items were stored in the cart. Interview with RN #3 (the Infection Preventionist) on 5/9/25 at 1:25 PM identified that he personally cleans the medication carts weekly on Mondays during environmental rounds and reported that he had just cleaned the carts on 5/5/25 and was unsure why expired medications and non-medication items were stored in the medication carts, reporting that they should not have been. He reported that he expected staff to keep the carts clean and free of expired medications and non medication items. 4. Observation and interview on 5/9/25 at 1:48 PM with LPN #2 at the South medication cart, identified house stock medications including Zinc Sulfate 220 mg tablets expired 1/2025, Hydrocortisone Acetate 25 mg suppositories expired 5/2/25 and Vitamin B-6 100 mg tablets expired 4/2025. The cart was noted to be overly sticky and at least one dozen loose pills were located on the floor of one of the drawers of the medication cart. LPN #2 identified that she was agency staff and hadn't worked at the facility in a long time but reported that the medication cart was unorganized and dirty and reported that expired medications should not be stored in the medication cart. Review of the Medication Storage in the Facility policy directed, in part, that all medications dispensed by the pharmacy are stored in the container with the pharmacy label. Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse will check the expiration date of each medication before administering it. No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining. The medication will be destroyed in the usual manner. Although requested, a policy on medication cart cleaning was not provided.

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	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	256 New Britain Avenue Newington, CT 06111

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on the tour of the Dietary Department, interview and facility documentation, the facility failed to identify expiration dates for dry stock and frozen items. The findings included: Tour of the Dietary Department on 5/9/25 at 12:05 PM with the Dietary Manager identified the following: a. The basement dry stock contained 16 individual bags of sliced white breads with no expiration date, 2 (1-gallon) coleslaw dressing jars with no expiration date and 4 (1-pound) cans of chicken base that lacked an expiration date. b. The walk-in basement freezer contained 12 packages of hot dog buns with no expiration date, 12 packages of hamburger buns with no expiration date, 2 plastic wrapped 5-pound beef chucks with no expiration dates, a 1 5-pound bag of chicken tenders with no expiration date and a 10-pound bag of chicken breast with no expiration date. Interview with the Dietary Director on 5/9/25 at 12:56 PM failed to identify the policy on expiration dates, and stated they were most likely on the boxes they were delivered in, but due to lack of room in the facility, items were removed from the boxes. She was unable to identify how the items with no expiration dates would be identified as expired without being labeled. Review of the Food policy directed in part that all food will be labeled and dated to allow for rotation of supplies. Review of the Shelf Life and Use of Frozen Foods policy directed in part that all foods should be covered, labeled and dated when it was freezed.

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	075393	A. Building B. Wing	05/13/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #1) reviewed for nutrition, the facility failed to ensure that meal percentages were consistently being documented for a resident with significant weight loss. The findings include: Resident #1's diagnoses included dementia without behavioral disturbances, dysphagia, severe protein-calorie malnutrition and type 2 diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and required substantial assistance for bed mobility. Additionally, the MDS identified that Resident #1 had a weight loss of 5 percent (%) or more in the last month or a loss of 10 % or more in the last 6 months. The Resident Care Plan (RCP) dated 4/28/25 identified Resident #1 had severe protein calorie malnutrition related to severe weight loss, dysphagia, loss of muscle and fat, low Body Mass Index (BMI) and blood work indicating inflammation despite intake being above the estimated needs. Interventions included to monitor the dietary intake as ordered. A nutrition note dated 4/23/25 at 3:08 PM identified that Resident #1's weight was down 4 pounds from the weight of the previous week. The nutritional note reported that blood work was obtained and indicated inflammation or chronic disease state was a factor affecting the resident's weight loss. The note identified that by mouth intakes averaged 50 %. An Advanced Practice Registered Nurse (APRN) progress note dated 4/25/25 at 10:00 AM identified that Resident #1 was evaluated for ongoing weight loss with poor meal intake of approximately 50 %. The note reported that nursing will monitor and report changes in oral intake. Review of April 2025 Documentation Survey Report (Nurse Aide documentation) identified that the meal intake percent (%) eaten for breakfast was not documented for Resident #1 on 4/1/25, 4/2/25, 4/7/25, 4/17/25, 4/22/25, 4/24/25 and 4/29/25. The meal intake percent (%) eaten for lunch was not documented on 4/1/25, 4/2/25, 4/3/25, 4/6/25, 4/7/25, 4/11/25, 4/14/25 through 4/17/25, 4/19/25, 4/21/25, 4/22/25, 4/24/25 through 4/26/25, 4/28/25 and 4/29/25. An APRN progress note dated 5/2/25 at 10:00 AM identified that Resident #1 continued to decline overall with continued weight loss and poor appetite with a meal intake of approximately 50 % and the resident was recently started on Mirtazapine 15 mg at bedtime as an appetite enhancer. Review of May 2025 Documentation Survey Report (Nurse Aide documentation) identified that the meal intake percent (%) eaten for breakfast was not documented for Resident #1 on 5/2/25, and 5/4/25. The meal intake percent (%) eaten for lunch was not documented on 5/1/25 through 5/9/25. The meal intake percent (%) eaten for dinner was not documented on 5/5/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075393	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel-Air Manor Nursing & Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Dietician on 5/12/25 at 12:28 PM identified that she averaged the resident's meal intakes within a certain timeframe to calculate intake trends to treat the resident appropriately, so she relied on the Nurse Aide's (NA's) to document accurately and consistently every meal so that the calculation was correct. She reported that for Resident #1, who has had a significant weight loss, the NA's were not documenting on each meal and although she doesn't believe it would affect her treatment plan, she expected that the NA's document the meal percentages eaten accurately and consistently and report any changes to nursing so that she can then be notified. Interview with the DNS on 5/12/25 at 1:04 PM identified that she expects that the NAs document completely and accurately for all tasks for each resident, reporting that she was not aware that they were not documenting on the meal percentages each meal for Resident #1 stating they should have been. She identified that the accuracy and completeness of the NA documentation is important for the care of each resident and that she will start reviewing the NA documentation more closely for omissions. Review of Charting and Documentation policy (undated) directed, in part, that Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy. Interview with RN #4 (Regional) on 5/12/25 at 2:35 PM identified that she could not locate a policy pertaining to NA documentation but reported that all NAs receive training on electronic documentation on hire and that all NAs are expected to document complete and accurate information for all populated tasks for all residents on their assignments. Although requested, a facility policy for Nurse Aide documentation was not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for 2 of 2 residents (Resident #23 and Resident #44) who transferred to the hospital and were reviewed for Multi-Drug Resistant Organisms (MDROs), the facility failed ensure at the time of transfer to an acute care hospital the MDRO colonization status, special instructions or precautions for ongoing care related to the MDRO were communicated to the receiving hospital. The findings include: 1. Resident #23 was admitted with diagnoses that included Parkinson's disease and chronic obstructive pulmonary disease (COPD). A lab result dated 6/24/24 identified Resident #23's sputum was positive for Extended- spectrum beta lactamase (ESBL-enzymes that identify antibiotic resistance) bacteria (Klebsiella) and Methicillin (antibiotic) resistance bacteria (staphylococcus) or MRSA. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 was alert and oriented and was independent for personal hygiene, ambulation with a walker and transfer. Resident #23 was occasionally incontinent of urine. The MDS did not identify Resident #23 had a MDRO (despite the lab result of 6/24/24 identifying MRSA and ESBL in the sputum). The Resident Care Plan (RCP) dated 10/22/24 identified Resident #23 had emphysema (lung disease) and was an active smoker. Interventions included aerosol treatments as ordered and elevate head of the bed. A nursing note dated 11/10/24 at 8:37 AM identified that Resident #23 was in respiratory distress and was transferred to the hospital emergency department (ED) via 911. Interview and review of the Multi Drug Resistant Organism (MDRO) log with RN #3, the Infection Preventionist on 5/9/25 at 11:00 AM identified Resident #23 was on the facility MDRO list and had facility acquired MRSA and ESBL in both the urine and nose as of 6/28/24 and again on 10/9/24. Nursing notes failed to identify that Resident #23's MDRO status was communicated on transfer to the hospital on [DATE]. 2. Resident #44 was admitted with diagnoses that included dementia and end stage renal disease. A lab result dated 11/26/24 identified Resident #44 had ESBL klebsiella (bacteria) in urine cultures. The Resident Care Plan (RCP) dated 11/7/24 identified Resident #44 was frequently incontinent of bladder with interventions that included incontinent care every 2 hours and as needed. (continued on next page)

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	075393	A. Building B. Wing	05/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hospital Discharge summary dated [DATE] identified Resident #44 had history of ESBL klebsiella (bacteria) in urine cultures. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 was moderately cognitively impaired and needed substantial assistance for personal/toilet hygiene, and transfer. Resident #44 was occasionally incontinent of urine. A nursing note dated 4/8/25 at 12:23 PM identified that Resident #44 was in respiratory distress and was transferred to the hospital emergency department (ED) via 911. Interview and review of the Multi Drug Resistant Organism (MDRO) log with RN #3, the Infection Preventionist on 5/9/25 at 11:00 AM identified Resident #44 was on the facility MDRO list and had community acquired ESBL in the urine. Nursing notes failed to identify that Resident #44's MDRO status was communicated on transfer to the hospital on 4/8/25. Interview with RN #3 on 5/12/25 at 12:30 PM identified that Resident #23 was transferred to the hospital on [DATE] and Resident #44 had been transferred to the hospital on 4/8/25. Both medical records lacked documentation that at the time of transfer to the hospital that the MDRO colonization status, any special instructions or precautions for ongoing care were identified and communicated to the hospital. He was aware that the facility needed to notify at the time of transfer to another facility of the MDRO status. RN #3 continued that it was the facility's process to inform the hospital verbally. He could not locate any documentation regarding information that was provided upon transfer to another facility (nursing notes, Inter-Agency Referral form/W10) for Resident #23 or Resident #44 and noted he did not monitor that aspect of the MDRO requirements. Interview with the DNS on 5/13/25 at 9:30 AM identified she was aware that the facility needed to notify on transfer a resident's MDRO status and this was completed when the transferring nurse provided verbal report. The documentation that was provided at transfer included the resident's face sheet that included diagnoses and the resident's medication profile. A copy was not retained, and the nurses were not completing the electronic transfer/discharge document that was a part of the electronic medical record, so she was unable to provide any documentation of communication of MDRO status and any precautions necessary upon transfer. Interview with RN #6, (Regional Nurse) on 5/13/25 at 11:30 AM identified that the face sheet would include the MDRO diagnoses but that the facility did not retain any copies of paperwork completed on transfer to the hospital and the electronic discharge form was not utilized. Resident #23's and #44's face sheet failed to include the MDRO diagnoses. The facility policy Control of MDRO colonization failed to identify the requirement to notify the hospital upon transfer of the MDRO status. The facility policy Guidelines for Methicillin- Resistant Staphylococcus Organism (MDRO) colonization identified in part, to notify other institutions as soon as possible of the resident's history of MRSA when planning inter-agency transfer to help ensure optimal infection control measures are instituted.