

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2024
NAME OF PROVIDER OR SUPPLIER  Bel Aire Center		STREET ADDRESS, CITY, STATE, ZIP CODE  35 Bel-Aire Drive Newport, VT 05855	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776</b></p> <p>Based upon interview and record review, the facility failed to report allegations of abuse to the appropriate agencies and responsible parties in the required timeframes for 1 resident [Resident #1] of 4 sampled residents.</p> <p>Findings include:</p> <p>Per review of the facility's Abuse Prohibition Policy [revised 10/24/22]:</p> <ul style="list-style-type: none"> <li>- Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked.</li> <li>- The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law</li> <li>- All reports of suspected abuse must also be reported to the patient's family and attending physician.</li> <li>- Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injury of unknown origin, or misappropriation of patient property must also report to outside agencies, if required.</li> <li>- Staff are obligated to report reasonable suspicion of a crime against the elderly to the state agency and local law enforcement. Administrators and Directors of Nursing must assist in reporting.</li> </ul> <p>Per record review, Licensed Nurse's Aide [LNA] #1 provided a witness statement on 7/19/24 regarding an incident that had occurred 4 days earlier on 7/15/24 involving Res.#1 and another LNA [LNA #2].</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per LNA #1's statement: I was working on A wing with [LNA #2] . [LNA #2] did not ask [Res.#1] if [s/he] would like care done, instead [LNA #2] grabbed [Res.#1] by [h/her] arm and made [h/her] walk to the bathroom. [Res.#1] wanted to go to the sink to start, [LNA #2] grabbed [Res.#1] by [h/her] arm and attempted to force [h/her] to walk backwards toward the toilet. [LNA #2] also raised [h/her] voice at [Res.#1] when [s/he] did not cooperate. [Res.#1] said ouch and other things like you're hurting me multiple times .I tried to speak softly to [Res.#1] as [s/he] asked questions like 'why were we trying to kill [h/her]' and why [h/her] daughter would put [h/her] in a place like this, although I really did not have much to say because I was in disbelief.</p> <p>LNA #1's statement continues with after witnessing the alleged resident abuse, I couldn't find a nurse to report this incident to until much later and there was too much going on. The next day, while the Nurse Educator and I were talking, [s/he] asked me how the previous evening had went (working with [LNA #2]) and I told [h/her] about the incident and that I didn't really know the proper steps to take, and [s/he] told me that I can go online and make a report or that I could call a number to report it. Per review of facility records, the Nurse Educator did not report the abuse allegation to the facility's DON or Administrator [ADM] and did not follow up with LNA #1 to verify the allegation had been reported to the required agencies.</p> <p>An interview was conducted with the Director of Nursing [DON] on 8/12/24 at 10:19 AM.</p> <p>The DON reported [s/he] first became aware of abuse allegations on 7/18/24 when an Adult Protective Services investigator arrived at facility.</p> <p>The DON stated that the Abuse Procedure is to immediately report to the charge nurse, if charge nurse is not present, to call the DON day and night regardless. The DON stated the Nurse Educator 'absolutely should' have reported the abuse allegations after speaking with LNA #1 and informed the DON and Administrator [ADM] but did not. The DON stated there was a disconnect with following the proper procedure, and the Nurse Educator dropped the ball.</p> <p>Per review of a report form received at the Division of Licensing and Protection on Thursday, July 18, 2024, at 2:22 PM, [3 days after the incident] the DON reported Today at around noon Adult Protective Services showed up to [NAME] Aire Center after they received a report of a LNA [#2] yelling loudly and dragging resident [Res.#1] to the toilet . There have been no reports in the building of anything like this, no documentation in the resident's chart of any situation.</p> <p>The DON confirmed that facility staff failed to report the allegation of abuse on 7/15/24 to the facility's DON, ADM, and the appropriate agencies and responsible parties in the required timeframes.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29776</p> <p>Based upon interview and record review, in response to allegations of abuse the facility failed to immediately investigate the allegations and to prevent further potential abuse for 1 resident [Resident #1] of 4 sampled residents.</p> <p>Findings include:</p> <p>Per review of the facility's Abuse Prohibition Policy [revised 10/24/22]:</p> <ul style="list-style-type: none"> <li>-Initiate an investigation within 24 hours of an allegation of abuse that focuses on: whether abuse or neglect occurred and to what extent.</li> <li>-The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation.</li> </ul> <p>Per record review, Licensed Nurse's Aide [LNA] #1 provided a witness statement on 7/19/24 regarding an incident that had occurred 4 days earlier on 7/15/24 involving Res.#1 and another LNA [LNA #2].</p> <p>Per LNA #1's statement: I was working on A wing with [LNA #2] . [LNA #2] did not ask [Res.#1] if [s/he] would like care done, instead [LNA #2] grabbed [Res.#1] by [h/her] arm and made [h/her] walk to the bathroom. [Res.#1] wanted to go to the sink to start, [LNA #2] grabbed [Res.#1] by [h/her] arm and attempted to force [h/her] to walk backwards toward the toilet. [LNA #2] also raised [h/her] voice at [Res.#1] when [s/he] did not cooperate. [Res.#1] said ouch and other things like you're hurting me multiple times.I tried to speak softly to [Res.#1] as [s/he] asked questions like 'why were we trying to kill [h/her]' and why [h/her] daughter would put [h/her] in a place like this, although I really did not have much to say because I was in disbelief. LNA #1's statement continues with after witnessing the alleged resident abuse, I couldn't find a nurse to report this incident to until much later and there was too much going on. LNA #1 stated that s/he reported the abuse allegation the next day during a conversation with the facility's Nurse Educator. Per review of facility records, the Nurse Educator did not report the abuse allegation to the facility's DON or Administrator [ADM] and did not follow up with LNA #1 to verify the allegation had been reported to the required agencies.</p> <p>An interview was conducted with the Director of Nursing [DON] on 8/12/24 at 10:19 AM.</p> <p>The DON reported [s/he] first became aware of abuse allegations on 7/18/24 when an Adult Protective Services investigator arrived at facility.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per review of a report form received at the Division of Licensing and Protection on Thursday, July 18, 2024, at 2:22 PM, [3 days after the incident] the DON reported Today at around noon Adult Protective Services showed up to [NAME] Aire Center after they received a report of a LNA [#2] yelling loudly and dragging resident [Res.#1] to the toilet . There have been no reports in the building of anything like this, no documentation in the resident's chart of any situation. The DON reported that it was after this occurred that the facility launched an investigation into the abuse allegation. Per record review, during the time of the witnessed alleged abuse, and the start of the investigation 3 days later on 7/18/24, LNA #2 was not immediately taken off duty or taken off the schedule after the incident on 7/15/24. Review of the facility's LNA schedule and LNA task record reveals that LNA #2 was assigned to and provided care to Res.#1 again on 7/17/24.</p> <p>The DON confirmed that an investigation into the abuse allegation should have been initiated immediately on 7/15/24 after the alleged event occurred, and that the staff member involved, LNA #2, should immediately have been taken off duty and taken off the schedule to prevent further potential abuse but was not.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29776</p> <p>Based upon interview and record review, the facility failed to implement care plan interventions regarding medications and physician orders for 1 resident [Res.#1] of 4 sampled residents.</p> <p>Findings include:</p> <p>Review of Res.#1's medical record reveals the resident was admitted to the facility on [DATE], with Physician Orders that included an order for 'Metoprolol: Give 1 tablet by mouth two times a day for blood pressure. Hold Metoprolol if Systolic Blood Pressure is less than 110 or Heart Rate is less than 65.'</p> <p>[Metoprolol is a medication that affects the heart and circulation and is used to treat angina (chest pain) and hypertension (high blood pressure)] (<a href="https://www.drugs.com/mtm/metoprolol-succinate-er.html">https://www.drugs.com/mtm/metoprolol-succinate-er.html</a>)</p> <p>[ A blood pressure reading has two numbers. The top number is called the Systolic Blood Pressure. The top number measures the pressure in the arteries when the heart beats.]</p> <p>(<a href="https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/in-depth/blood-pressure">https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/in-depth/blood-pressure</a>)</p> <p>Review of Res.#1's Care Plan reveals the resident is identified as exhibits or is at risk for cardiovascular symptoms or complications related to heart failure. Care Plan interventions include Administer meds as ordered</p> <p>Review of Res.#1's medical record and Medication Administration Record [MAR] beginning on 7/13/24 and continuing through the day of the complaint investigation on 8/12/24 reveals that Res.#1's Systolic Blood Pressure and/or Heart Rate were below the physician prescribed parameters 16 times, yet the blood pressure medicine Metoprolol was still administered. Further review reveals no documentation in Res.#1's medical record of why the medication was given in error or that the physician was notified of the medication order not being followed.</p> <p>An interview was conducted with the Director of Nursing [DON] on 8/12/24 at 10:19 AM.</p> <p>The DON confirmed that the Metoprolol medication order requires the medication to be held when below certain parameters, and despite the physician ordered parameters, the medication was not administered as ordered per the resident's Care Plan on 16 occasions between 7/13 and 8/12/24.</p>		