

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 09/02/2025
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)		
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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
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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 0760 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #1) of three sampled residents was free from significant medication errors which resulted in a resident developing DVT [Deep Vein Thrombosis] and being transferred to the emergency department. Findings include: Per record review of Resident #1's EMR [Electronic Medical Record] Resident #1 has diagnoses of a right femur fracture, muscle weakness, anxiety, and atrial fibrillation [a condition where the heart beats irregularly]. Resident #1 has a BIMS [Brief Interview of Mental Status] score of 7 as of 8/4/25, indicating Resident #1 has cognitive impairment. The resident is dependent on staff for ADLs [Activities of Daily Living] and hygiene. Per record review, Resident #1 was admitted to the hospital on [DATE] for a hip fracture and was discharged on 8/1/25. Per record review of Resident #1's discharge summary from the hospital on 8/1/25 contains a medication reconciliation section with the order Enoxaparin 40 mg [milligram/ 0.4 mL [milliliter] injectable solution 0.4 milliliters subcutaneous (under the skin) every 24 hours for 30 days. Per record review of Resident #1's August 2025 MAR [Medication Administration Record] Resident #1 was prescribed Enoxaparin Sodium Solution 40 mg [milligrams]/ 0.4 ml [milliliter]: Inject 40 mg subcutaneously one time a day for prevent blood clotting for 10 days. The order is written to start 8/2/25. S/he was administered the medication from 8/2/25 to 8/11/25. Three licensed nursing staff members administered this medication over the 10-day period. Per record review of the facility's OPS424 Medication Reconciliation policy [last revised 12/16/24] states, 3. For patients admitted from the hospital: 3.1 obtain and review copies of the Medication Administration Records (MARs), Treatment Administration Records (TARs), transfer forms, and Physician's Order Sheets (POS). 3.1.1 Verify MAR/TAR information with transfer forms and POS, if available. 3 Clarify medication orders with clinical staff from transferring hospital, when necessary 5.4 Any discrepancies discovered during reconciliation will be reported to the physician/APP [Advanced Practice Physician] before finalizing the current list of medications. Per record review of Resident #1's progress note written by the NP [Nurse Practitioner] on 8/26/25 at 11:44 AM states, Acute visit for DVT [Deep Vein Thrombosis] documented by ultrasound after ER [Emergency Room] transfer on 8/24 with reported 10 cm x 5.5 cm area of pain and redness which was enlarging. It was additionally noted that Lovenox [an injection that is used to help prevent blood clots] therapy was ordered for 30 days on discharge summary and given for 10 days; lapse of expected therapy for 12 days. Per record review of the ultrasound performed on 8/24/25 at the emergency department states, Impression: There is superficial thrombophlebitis involving a subcutaneous vein in the anterior right thigh as well as the great saphenous vein at the saphenofemoral junction. The latter extends into the anterior aspect of the common femoral vein, as an equivalent to deep venous thrombosis. An interview with the NP was conducted on 9/2/25 at 10:02 AM. The NP stated that the discharge order is checked when reconciling medication. She stated two nurses are supposed to check the order. She discussed she was called the morning of the visit to the emergency department visit by staff discussing the thigh swelling with a bruise type area. She stated, This was a med [medication] error. This should not have happened. An interview was conducted with LPN [Licensed Practice Nurse] #1 on 9/2/25 at 10:09 AM. LPN#1 stated she transcribed the orders from the resident's discharge papers. She stated, I did not hand off the check to the next person. I'm not sure if I should have. I wasn't alone that day but I'm not sure what happened. I don't know the process. [After the resident was sent to the hospital] They did an in-service education with a quiz. I still don't know the process. I'm trying to figure it out myself. An interview was conducted with the DON [Director of Nursing] on 9/2/25 at 10:50 AM. The DON stated, Most days orders come in and unit clerk puts them in. She wasn't here that day. Then [the medication is] recheck [ed] from admitting nurse, checked again by a second time. The order was not checked a second time.</p>		