STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475049	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel Aire Center	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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident was free from physical restraints for 1 of 1 applicable resident (Resident #2) related to a seat belt that the resident was unable to remove on their own. Findings include:Per record review, Resident #2 was admitted to the facility on [DATE] with diagnoses that include dementia, schizophrenia, and seizure disorder.Resident #2's admission Minimum Data Set (MDS; a comprehensive assessment) dated 7/18/25 indicates that s/he is dependent on staff for self-care and functional cognition and needs staff assistance for mobility. His/her cognitive skills for daily decision making are marked as severely impaired.Resident #2's care plan's focuses include Resident is at risk for falls: cognitive loss, lack of safety awareness, Impaired mobility, initiated on 7/16/25, and Resident uses Seat Belt for safety and security, initiated on 7/16/25. Interventions include the use of a Velcro seat blet, initiated on 7/16/25.A Restraint Evaluation/Reduction, was completed for Resident #2 on 7/16/25. It reads, a restraint can only be used to treat a medical symptom and not to manage behavior, provide convenience, discipline or because of any specific diagnosis. The form indicates that the medical symptom is dementia, and the restraint/device type is a Velcro seat belt used as an enabler/reminder for safety.Per review of Risk Management System reports, Resident #2 had 4 unwitnessed falls in September 2025; 9/4/25, 9/6/25, 9/8/25, and 9/17/25. Reports indicate that on 9/17/25, Resident #2 had gotten up from wheelchair unassisted and was walking and fell, suffered a laceration to his/her face, and was transferred to the Emergency Room. Per interview on 10/14/25 at approximately 11:00 AM, the Director of Nursing (DON) stated that there are no residents in the facility with a restraint. She explained that there are only two residents in the facility that use seat belts, one being Resident #2.Per observation on 10/14/25 at approximately 12:30 PM, Resident #2 was sitting by the nursing station in his/her wheelchair. S/He did not appear to have a belt on his/her chair.Per interview on 10/14/25 at 12:38 PM, Licensed Practical Nurse #1 (LPN) explained that Resident #2 wears a seat belt all the time. The LNAs (licensed nursing assistants) are supposed to document in the Kardex (LNA documentation system) when it is used and licensed nurses should evaluate Resident #2's ability to remove the belt every shift.Per interview on 10/14/25 at 12:40 PM, LPN #2 stated that she was Resident #2's nurse for the day but is new to working with Resident #2. S/he was unsure if Resident #2 should be wearing a seat belt while in the chair. LPN #2 was observed to check Resident #2 for a seat belt and confirmed that s/he was sitting in the wheelchair without a seat belt on.Per interview on 10/14/25 at 12:42 PM, the Unit Manager stated that Resident #2 should have a seat belt on at all times when sitting in their wheelchair. In a follow up interview at 1:24 PM, the Unit Manager explained that the DON had asked her to take the seat belt off from Resident #2's wheelchair today because Resident #2 was unable to remove it on his/her own.Per interview on 10/14/25 at 1:26 PM, the DON stated that Resident #2 is not cognitively able to remove the seat belt on command. The DON confirmed that Resident #2 had a buckle seat belt on as of today and was unable to provide any information as to when s/he was switched from a Velcro belt to a buckle seat belt.Per interview on 10/14/25 at 1:35 PM, the Nurse Practitioner stated that Resident #2 used a seat belt for fall prevention and was not cognitively able to remove the seat belt on command. The NP confirmed that Resident #2's buckle seat belt would be considered a restraint.Per phone interview on 10/15/25 at 3:17 PM, Resident #2's Representative explained that Resident #2 used to have a Velcro seat belt, but it was changed to a seat belt with a button after his/her last fall. The Representative doesn't remember the facility letting him/her know of the change or getting consent for that change but had noticed a change after a visit with Resident #2 after their last fall. The Representative explained that the seat belt was used to prevent Resident #2 from falling. Per record review, Resident #2 does not have a physician order for a buckled seat belt that specifies a medical symptom, frequency of use and release time, and activities to be performed during release. Resident #2's care plan was updated on 9/30/25 to remove the use of a Velcro seat belt and change to seat belt. Resident #2's medical record, including their care plan, does not include documentation of how the use of the seat belt would treat a medical symptom that warrants the use of restraints, the type of direct monitoring and supervision that will be provided during use of the restraint, recommendations for gradual reduction, or address any risks related to the use of the restraint. The is no evidence that consent was obtained for the use of a buckle seat belt. There is no evidence of completed restraint assessments after the initial evaluation completed on 7/16/25.Per a virtual interview on 10/17/25 at 9:30 AM, the DON was unable to determine who or when Resident #2's Velcro seat belt was changed to a buckle seat belt. The DON confirmed that the

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents remained as free from accidents as possible related to falls for 3 of 3 sampled residents (Residents #1, #2, and #3) by failing to ensure assistive devices functioned properly, provide adequate supervision, and create and implement effective, timely interventions that would reduce the likelihood of future falls. As a result, Resident #1 suffered a fall that resulted in pain, a fractured nose, a left humerus (upper arm bone) fracture, and rib fractures. This is a repeat deficiency for this facility, with the violations cited during the previous recertification survey dated 7/17/25. Findings include:1. Per record review, Resident #1's care plan reveals that s/he needs assistance or is dependent on staff to perform activities of daily living (ADLs) and uses a wheelchair. His/her care plan includes the focus [Resident #1] is at risk for falls related to hx [history] of falls, poor safety awareness, unsteady gait, created on 2/10/22, including an intervention for Seat belt w/c [wheelchair] for fall reminder Monitor for safe use of belt Anti lock breaks on w/c, revised on 4/14/25. Physician orders include, Resident may use seat belt in w/c as [s/he] tolerates if resident can demonstrate safe use, start date of 11/4/22, and Assist resident qshift [every shift] when up in w/c with seat belt use, start date of 11/4/22. Regular progress notes reveal that Resident #1 can demonstrate removing the seat belt easily. Resident #1 has a BIMS (Brief Interview for Mental Status) of 10 as of 9/25/25 indicating moderate cognitive impairment. A Risk Management System (RMS) report of an unwitnessed fall dated 10/3/25 reads, Resident found on the floor laying on [his/her] right side, with foot under wheelchair, laying on [his/her] right arm, blood on the floor next to the resident's face, nosebleed from right nostril, hematoma to right forehead, laying in the hallway in front of [his/her] room door. Resident's seat belt on [his/her] wheelchair was loose. The report indicated that Resident #1 complained of 6 out of 10 pain and was sent to the ER (emergency room) for evaluation and treatment.A 10/7/25 Nurse Practitioner (NP) note describes that Resident #1 suffered nasal, humerus, and rib fractures, and is staying more in [his/her] room due to embarrassment of [his/her] facial bruising and need for more assistance.Slightly anxious affect, self-conscious about [his/her] facial bruising.Per record review, nursing notes show that Resident #1 reported 7 out of 10 multiple times between 10/3/25 through 10/15/25. Per interview and observation on 10/14/25 at 10:00 AM, Resident #1 was in the dining room, in his/her wheelchair. When asked about his/her current wheelchair and seat belt, s/he explained that s/he just got a new wheelchair moments ago and the one s/he is in doesn't have a seat belt (for which s/he is care planned for to prevent falls). S/he said s/he has had a seat belt for a long time because it reminds him/her not to stand up on his/her own. When asked about his/her most recent fall, s/he explained that s/he fell on [DATE] because s/he was trying to reach for something on the ground. S/He said the seat belt had been broken for a few days and it wasn't tight around his/her waste like normal, so when s/he reached down, the belt wasn't tight enough to reminder him/her not to get up, s/he fell, and the wheelchair tipped over on him/her. S/he explained that staff were not around when this happened. S/He explained that his/her face, head, arm, and ribs were injured from the fall, and it is painful. Resident #1 is noted to have bruising under both eyes, their left arm is in a sling, and s/he grimaced in pain when moving.Per phone interview with Resident #1's Representative on 10/14/25 at 2:30 PM, s/he explained that a staff informed him/her that Resident #1's belt was broken on 10/1/25. The Representative stated that the end of the belt had been tied, as the belt clip was broken and could not be repaired, and that the belt remained loose in this state. Per interview with the Nurse Practitioner (NP) on 10/14/25 at 1:35 PM, she revealed she was aware that Resident #1's seat belt had been tied on after it had been found damaged. She confirmed that Resident #1's seat belt did not function properly the day s/he fell. S/He said the belt was loose enough not to work as a reminder but tight enough to take the chair with them when they fell. Per interview with the Maintenance Director on 10/14/25 at 1:50 PM, he stated that nursing staff had notified him that Resident #1's seat belt was broken, and upon examining the belt to confirm it was broken, he informed nursing staff that he could not fix it. The Maintenance Director stated that nursing staff told him they would just tie it on. He explained that he ordered a new belt after he was notified that it was broken but it had not come in. He explained that the order was never processed because the facility had been cut off and the account had been closed but he was never notified that it did not go through.The Maintenance Director explained that a paper maintenance log at the nursing station is used to track needed repairs instead of the facility's TELS electronic system, because the girls just won't use TELS. The Maintenance Director was unable to produce the paper maintenance logs for the period prior to