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	04/01/2026

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 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were updated with a new intervention for 1 of 3 residents sampled (Resident #1). As a result, the resident sustained a necrotic ulcer on his/her right foot related to improper application of an Unna boot (compression dressing impregnated with healing agents) requiring admission to the hospital which later resulted in a below the knee amputation. Findings include: Per record review, Resident #1 had a BIMS (Brief Interview of Mental Status) of 14, indicating no cognitive impairment. Resident #1's medical diagnoses include peripheral vascular disease (PVD) (a disorder of blood vessels that affects blood flow to the limbs), type 2 diabetes mellitus with diabetic neuropathy, and a history of peripheral artery disease (PAD; a disorder of blood vessels that affects blood flow to the limbs) with revascularization (surgical procedure performed to restore blood flow to the leg). Per record review of care plan Resident #1 is at risk for skin breakdown related to advanced age, fragile skin, DM (diabetes mellitus), created on [DATE]. Per record review, a [DATE] Physician note reveals that Unna boots were applied to Resident #1 in response to increased edema, soreness, and redness. Resident #1 had a physician order for Unna boots starting on [DATE] to be applied to lower extremities 2 times a week. Per review of Resident #1's Treatment Administration Record for [DATE], Unna boots were applied on [DATE] and changed on [DATE] by Nurse #1. Per record review of [DATE] and [DATE] skin checks, there is no documentation of a wound on Resident #1's right foot prior to application of the Unna boot.Per record review, Resident #1 was transferred to the Emergency Department (ED) on [DATE] for tachycardia (increased heart rate) and chest pain.Per review of Hospital Emergency Department notes dated [DATE], Resident #1 had Unna boots applied the day before ([DATE]) and reported increasing leg pain. S/he denied having any ulcers, blisters or redness on her right foot prior to application of Unna boots. Per review of the Hospital admission History and Physical Report dated [DATE], bilateral Unna boots were removed in the ED, and a large wound measuring 4 cm (centimeters) x 3 cm was found on the right dorsal (upper) foot that was very painful for Resident #1.Per review of a Hospital Physician note dated [DATE], [Resident #1] was being treated with Unna boots in the nursing home, and it seems [s/he] might have had one that was too tight and caused [him/her] pressure injury.Per review of the Hospital Discharge summary dated [DATE], it was noted that tight Unna boots were placed on Resident #1 by the Skilled Nursing Facility. On arrival to the Emergency Department s/he had a large necrotic ulcer on his/her right dorsal foot that was likely ischemic (condition of blood flow being blocked or reduced) in nature and complained of severe pain. Surgical debridement (removal of nonviable tissue) was performed on [DATE], and it was determined that the wound was unlikely to heal due to the extent of the ulcer and comorbidities. Resident #1 was being transferred to a tertiary center for management of this ischemic ulcer and likely associated osteomyelitis [bone infection]. Likely to require an amputation. Per interview with Resident Representative #1 on [DATE] at 10:03 AM, Resident #1 was transferred to another hospital on [DATE] for a below-the-knee amputation, which occurred on [DATE]. The resident was scheduled for a second surgery to amputate above the right knee but died before that could occur.Per interview (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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F 0657 Level of Harm - Actual harm Residents Affected - Few	with the Facility Medical Director on [DATE] at 1:18 PM, she stated that the hospital notified her that (Resident #1's) Unna boot was applied incorrectly.Per record review of Resident #1's care plan, his/her care plan was not updated to include the application and management of Unna boots.Per the facility's Skin Integrity and Wound Care Management policy, staff will monitor and observe the patient for changes and review and revise the care plan as indicated. Per interview with Director of Nursing (DON) on [DATE] at 11:00 AM, he confirmed that all new nursing interventions should be incorporated into the care plan.

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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 0726 Level of Harm - Actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide education and ensure nursing competencies regarding the application and monitoring of an Unna boot (compression dressing impregnated with healing agents) for 3 of 3 nursing staff. As a result, Resident #1 developed a large necrotic ulcer on his/her foot requiring admission to the hospital which later resulted in a below the knee amputation.Findings include:Per record review, Resident #1 had a BIMS (Brief Interview of Mental Status) of 14, indicating no cognitive impairment. Resident #1's medical diagnoses include peripheral vascular disease (PVD) (a disorder of blood vessels that affects blood flow to the limbs), type 2 diabetes mellitus with diabetic neuropathy, and a history of peripheral artery disease (PAD; a disorder of blood vessels that affects blood flow to the limbs) with revascularization (surgical procedure performed to restore blood flow to the leg). Per record review of care plan Resident #1 is at risk for skin breakdown related to advanced age, fragile skin, DM (diabetes mellitus), created on [DATE]. Per record review, a [DATE] Physician note reveals that Unna boots were applied to Resident #1 in response to increased edema, soreness, and redness. Resident #1 had a physician order for Unna boots starting on [DATE] to be applied to lower extremities 2 times a week. Per review of Resident #1's Treatment Administration Record for [DATE], Unna boots were applied on [DATE] and changed on [DATE] by Nurse #1. Per record review of [DATE] and [DATE] skin checks, there is no documentation of a wound on Resident #1's right foot prior to application of the Unna boot.Per record review, Resident #1 was transferred to the Emergency Department (ED) on [DATE] for tachycardia (increased heart rate) and chest pain.Per review of Hospital Emergency Department notes dated [DATE], Resident #1 had Unna boots applied the day before ([DATE]) and reported increasing leg pain. S/he denied having any ulcers, blisters or redness on her right foot prior to application of Unna boots. Per review of the Hospital admission History and Physical Report dated [DATE], bilateral Unna boots were removed in the ED, and a large wound measuring 4 cm (centimeters) x 3 cm was found on the right dorsal (upper) foot that was very painful for Resident #1.Per review of a Hospital Physician note dated [DATE], [Resident #1] was being treated with Unna boots in the nursing home, and it seems [s/he] might have had one that was too tight and caused [him/her] pressure injury.Per review of the Hospital Discharge summary dated [DATE], it was noted that tight Unna boots were placed on Resident #1 by the Skilled Nursing Facility. On arrival to the Emergency Department s/he had a large necrotic ulcer on his/her right dorsal foot that was likely ischemic (condition of blood flow being blocked or reduced) in nature and complained of severe pain. Surgical debridement (removal of nonviable tissue) was performed on [DATE], and it was determined that the wound was unlikely to heal due to the extent of the ulcer and comorbidities. Resident #1 was being transferred to a tertiary center for management of this ischemic ulcer and likely associated osteomyelitis [bone infection]. Likely to require an amputation. Per interview with Resident Representative #1 on [DATE] at 10:03 AM, Resident #1 was transferred to another hospital on [DATE] for a below-the-knee amputation, which occurred on [DATE]. The resident was scheduled for a second surgery to amputate above the right knee but died before that could occur.Per interview with the Facility Medical Director on [DATE] at 1:18 PM, she stated that the hospital notified her that (Resident #1's) Unna boot was applied incorrectly.Per review of facility training records, no Unna boot training or competency, including how to apply or monitor the use of, was found for 3 of 3 nurses (Nurses #1, #2, and #3) prior to Resident #1 being transported to the ED on [DATE]. Nurse #1 who applied Resident #1's Unna boots on [DATE] and [DATE], did not have record of wound care competencies.Per interview with the DON and Facility Administrator on [DATE] at approximately 12:50 PM, they both confirmed there is no wound care or Unna boot training or competencies on record for Nurse #1. They failed to provide documentation of training on Unna boot application and monitoring for any nursing staff prior to [DATE].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection control policies regarding Enhanced Barrier Precautions (EBP; staff use of gown and gloves during high contact care) for 1 of 1 sampled residents. Findings include: Per the facility's Enhanced Barrier Precautions policy, reviewed on 4/1/2026 at 2:00 PM, patients with wounds or indwelling medical devices, regardless of multidrug-resistant organism colonization status, should be on EBP.Per observation on 4/1/2026 at 1:45 PM, the Wound Care Specialist failed to put a gown on before changing Resident #2's wound vac (a device that uses negative pressure to promote wound healing) and performing wound care. When interviewed immediately after wound care, she stated she felt she did not need to wear a gown. Per interview on 4/1/2026 at 2:10 PM, the Director of Nursing (DON) confirmed that Resident #2 should be on EBP due to wound status/presence of a wound vac, and that the nurse providing wound care should have worn a gown to prevent cross-contamination between the wound and clothing.