

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 07/17/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation and interview, the facility failed to ensure one resident [Resident #4] of 3 sampled residents was treated with respect and dignity regarding personal medical equipment. Findings include: Per record review of the facility's OPS206 Resident Rights Under Federal Law policy [last revised 2/1/23] states, Purpose: to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their self-esteem and self-worth. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Per record review, Resident #4 has major diagnoses of BPH [Benign Prostatic Hyperplasia, a condition that causes an enlargement of the prostate), Type II Diabetes Mellitus, and spinal stenosis (a condition that causes a narrowing of spaces in the spinal canal). Resident #4's MDS [Minimum Data Set] states that Resident #4 is dependent on staff for ADLs [Activities of Daily Living] and hygiene. Resident's BIMS [Brief Interview of Mental Status] score was 15, indicating Resident #4 was not cognitively impaired. Per record review of Resident #4's care plan states, Monitor [foley catheter] for odor, color, consistency, and amount .provide privacy and comfort. provide privacy bag. This section of the care plan was last revised on 6/25/25. Per observation on 7/15/25 at 10:30 AM, Resident #4's foley bag was not covered with a privacy bag. The foley was draining yellow urine. An interview was conducted with LPN#1 on 7/15/25 at 2:38 PM. LPN #1 confirmed that the foley bag had no privacy bag and stated, I'll go do that now. Per observation on 7/16/25 at 9:51 AM, Resident #4's foley bag still did not have a privacy bag over it and the foley was draining yellow urine. Per interview with Resident #4 on 7/16/25 at 10:03 AM, Resident #4 stated I would like it properly covered, especially if I were in public. Per observation on 7/17/25 at 10:40 AM, Resident #4's foley bag was not covered with a privacy bag and was draining yellow urine.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received adequate interventions to prevent accidents for 2 residents [Residents #25 & #35] of 4 sampled residents. Findings include:1) Per review of Resident #25 medical record, Resident #25 has medical diagnoses of COPD [Chronic Obstructive Pulmonary Disease], history of a TIA [Transient Ischemic Attack, a transitory blockage of blood to the brain], muscle weakness, and anxiety. Resident #25's BIMS [Brief Interview of Mental Status, a tool to assess cognitive function in residents] score was 3, indicating the resident is cognitively impaired. Resident #25's MDS [Minimum Data Set, an assessment tool for clinical evaluation of residents] states that Resident #25 is dependent on staff for ADLs [Activities of Daily Living] and hygiene and is occasionally incontinent of bowels.</p> <p>Per record review of a physician progress note written on 7/7/25 at 12:00 AM states, "Per nursing documentation [s/he] had a fall around 22:30 on 7/2/25 and another at 03:00 on 7/3/25. [Resident #25] was noted to have a skin tear of [his/her] right forearm after the first fall. Later in the morning on 7/3/25, [s/he] was noted to have a large hematoma over the left scapula and appeared short of breath. SpO2 [Oxygen Saturation level] at the time was 79% on RA [room air] so home nocturnal oxygen was applied with improvement, and provider was contacted to request to send pt [patient] to ED [Emergency Department]. In the ED, it was also apparently reported that someone had seen bleeding from [Resident #25]'s left ear. No blood was noted on exam. FAST ultrasound of thorax was performed and demonstrated right and left pleural effusions (an accumulation of fluid in the pleural space of the lungs) but no other abnormalities. Chest x-ray showed chronic left pleural effusion and possible tiny right pleural effusion;CT of head demonstrated acute intra-axial hemorrhage of left frontal lobe measuring 1.8 x 1.6 cm without associated midline shift or upward or downward herniation, with a small subarachnoid component present superficial to intra-axial hemorrhage."</p> <p>Per record of Resident #25's care plan states, "Resident is at risk for falls r/t [related to] weakness and deconditioning. History of frequent falls and poor safety awareness." This was added on 6/19/25. Interventions after the fall on 7/2/25 were added and included the following: "Send to ED for evaluation, Observe for changes in medical status, pain status, mental status and medication side effects that may contribute to cognitive loss/dementia/delirium and can lead to increase fall risk. report MD as indicated .Implement the following safety precautions: Remind resident often not to self transfer and to use [his/her] call bell to ring for assistance. Ensure resident has call bell within reach at all times, and Resident now resides in the room closest to the nurse's station for increased safety monitoring."</p> <p>Per record review of a nurse progress note written 7/12/25 at 5:04 AM states, "Staff heard a noise at 0415, found [Resident #25] on the floor between [his/her] bed and the wall. Assessed for injuries, small laceration above right eye, raised area above left eye, 2 skin tears on left shin, areas both bleeding, bleeding stopped, areas cleansed, dressing applied, two assist up off the floor, called lumina [physician], updated, she ordered to send to ER for evaluation and treatment."</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Per record review of a physician note written on 7/14/25 at 2:23 AM states, "Called regarding [Resident #25], who sustained a fall. Reports a recent history of a fall that resulted in a brain bleed. The current fall involved hitting [his/her] head again, causing a bleeding scalp laceration. Advised to send the patient to the hospital for evaluation due to the new head injury in the context of a recent intracranial hemorrhage&hellip;The patient [Resident #25], experienced a fall today, 07/12/2025. This fall resulted in a head injury with an associated bleeding laceration. This event is concerning given a recent history of another fall that caused a brain bleed. Due to the [sic] repeat head trauma and active bleeding, immediate transfer to a hospital for emergency assessment was done. Vital signs could not be obtained at the time of the call given patient was transported to ed [Emergency Department]."</p> <p>Per record review, there were no additional medical documents from the Emergency Department found in the EMR [Electronic Medical Record]. Resident #25's care plan was not updated after the fall on 7/12/25.</p> <p>Per record review of the facility's "OPS416 Person-Centered Care Plan" policy [last revised 10/24/22] states, "7. Care plans will be: 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly assessments, and as needed to reflect the response to care and changing needs and goals; and 7.3 Documented on the Care Plan Evaluation Note."</p> <p>Per record review of the facility's "NSG215 Falls Management" policy [last revised 3/15/24] states, "Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented; PURPOSE to ensure the patient-centered care plan is reviewed and revised according to the patient's fall risk status. 2. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. 2.1 Adjust and document individualized intervention strategies as patient condition changes."</p> <p>An interview was conducted with the DON [Director of Nursing] on 7/16/25 at 2:02 PM. The DON confirmed Resident #25 did not have any additional interventions in his/her care plan after second fall. The DON was unable to produce any additional neurological checks. She was unable to provide any additional documentation related to the fall on 7/12/25 in the patient's medical record.</p> <p>Works Cited:</p> <p>Pleural Effusion. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/17373-pleural-effusion. Accessed 7/24/25.</p> <p>Transient Ischemic Attack. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/transient-ischemic-attack/symptoms-causes/syc-20355679. Accessed 7/22/25.</p> <p>2) Per record review, Resident #35 was admitted to the facility with diagnoses that include weakness, cognitive impairment, and a history of falling. Review of Resident #35's Care Plan reveals the resident is identified as "at risk for falls: Impaired mobility, history of stroke, and left-sided weakness." Per interview with the resident and h/her sister on 7/15/25 at 1:01 PM, the sister stated the resident has had multiple falls since admission and was recently found on the bathroom floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Per review of Progress Notes for Resident #35 dated 6/3/25, "Registered Nurse asked this writer to check on [Resident #35] because she heard a bang. This writer found [Resident #35] sitting on [h/her] bottom leaning against the closet door. [S/he] was assisted to sitting position then assisted to the bed to sit on."</p> <p>An interview was conducted with the Director of Nursing [DON] on 7/16/2025 at 1:55 PM. The DON stated that a new intervention should have been added to the resident's care plan to prevent future falls after the fall on 6/3/25 but was not. The DON reported that DON stated intervention for the 6/3/25 fall was listed in an incident report but not included in the care plan. The Incident report lists a Physical Therapy screen/evaluation to be conducted for the resident on 6/5/25.</p> <p>An interview was conducted with the Physical Therapist [PT] on 7/17/2025 at 12:49 PM. The PT reported that a screening had been attempted with Resident #35 after the fall on 6/3/25 but the resident had refused to be evaluated or participate in any therapy sessions that may have prevented future falls. The therapist confirmed that without a therapy evaluation nothing about the resident's care or treatment was changed. Per interview with the DON on 7/17/25 at 1:30 PM, the DON confirmed the therapy screening and evaluation was the only new intervention to be attempted to prevent future falls and was rejected by the resident. The DON confirmed the facility failed to evaluate the effectiveness of the intervention, and no other alternative interventions were considered or implemented to prevent future falls for the resident.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on interview and record review, the facility failed to treat and manage 1 of 2 sampled resident's pain [Resident #40] per physician orders and plan of care. Findings include: Per record review, Resident #40 was admitted to the facility with diagnoses that include Arthritis: multiple sites. Per interview with the resident on 7/15/2025 at 11:33 AM, Resident #40 stated I have pain in my neck [a pinched nerve]. I have pain patches for my neck. I had them for 2 days, then none yesterday and none yet today. They told me they don't have an order for one. Per review of Physician Orders for Resident #40, an order dated 7/11/25 reads Lidocaine External Patch (4 % Lidocaine). Apply to Left side of posterior neck topically in the morning for neck muscle/skeletal issues for 10 Days -Start Date 7/11/2025 8:00 AM. Review of Resident #40's Medication Administration Record [MAR] for July 2025 reveals on 7/14/25 a marking for NN [Nursing Note] for the pain patch administration. Review of Nursing Notes dated 7/14/25 at 11:46 AM regarding the pain patch reveal the notation unavailable. Further review of Nursing Notes on 7/14/25 record Ask resident if they are having pain. Document pain level and new onset in supplementary documentation and document location of pain. If not new initiate non-pharmacological interventions and document interventions and effectiveness. Nursing documentation notes Resident #40 complaining of posterior neck pain with no non-pharmacological interventions attempted to relieve it. Review of Resident #40's Care Plan reveals interventions that include Administer medications as ordered and observe for effectiveness and side effects and report to Physician as indicated. An interview was conducted with the Director of Nursing [DON] on 7/16/2025 at 1:55 PM. The DON stated that if a medication is unavailable the resident's physician should be notified to order a hold or a substitute. The DON confirmed there was no documentation that the physician was notified Resident #40 did not receive h/her pain medication as ordered and no attempt to relieve the pain through non-pharmacological interventions.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based upon observation, interview, and record review, the facility failed to provide sufficient nursing staff to maintain the highest practical physical, mental, and psychosocial wellbeing of the facility's residents. Findings include: Per observation on 7/16/25 at 11:53 AM, Resident #4 was observed in his bed when s/he was delivered his/her breakfast. S/he rang his/her call light at 11:53 AM. Resident #4's call light was answered at 12:15 PM. It took 23 minutes for the call light to be answered. S/he discussed with the nursing staff who entered the room that s/he needed to use the restroom. Per observation on 7/17/25 at 9:27 AM, a call light went off for Resident #6. The call light was answered at 9:58 AM. The call light was not answered for 31 minutes. Per observation at 9:58 AM Resident #1 stated to the licensed nursing staff member that s/he needed hygiene care. An interview was conducted with Resident #40 on 7/15/25 at 11:36 AM. S/he stated, 'Sometimes I have to wait so long it soaks through my briefs into my clothes. I can't get up to go; if I could, I would. It usually happens around 4:00 PM. S/he discussed this is usually the change of shift. S/he stated, 'They [the nursing staff] tell me 'There's only two of us' or 'I'm covering this side all by myself.' Resident #40 has a BIMS [Brief Interview of Mental Status] score of 14, indicating s/he has no cognitive impairment. An interview was conducted with Resident #5 on 7/15/25 at 1:05 PM. Resident #5 discussed that s/he does not feel the facility has enough staff. S/he discussed that s/he has had to wait up to 45 minutes to an hour for his/her call light to be answered and that this happens several times a week. S/he discussed that they have had episodes of incontinence in bed from having to wait for staff to answer his/her call light. Resident #5 had a BIMS score of 15, indicating they have no cognitive impairment. An interview was conducted with Resident #4 on 7/16/25 at 11:41 AM. Resident #4 stated, 'There is not enough staff. Resident #4 discussed that nursing staff often say 'We are busy when answering his/her call light. S/he discussed that it often takes over ten minutes for call lights to be answered. Resident #4 had a BIMS score of 15, indicating they did not have any cognitive impairment. An interview was conducted with LPN [Licensed Practical Nurse] #1 on 7/16/2025 at 1:06 PM. She stated she smelled odors due to lack of care. She discussed that she had to work overtime or pick up extra shifts on a weekly basis. She discussed that she could not get her work done stating, 'I tried everything just to stay afloat. LPN #1 discussed that numerous family members have complained about the staffing. She stated that she often did not take breaks, and when she did they were between five and ten minutes. An interview was conducted with LNA #1 [Licensed Nursing Assistant] #1 on 7/17/25 at 9:08 AM. She stated she must work extra shifts several times a month. She stated working extra shifts and overtime was aggravating. LNA #1 stated some days the nursing staff do not get breaks because LNAs are helping with breakfast. She discussed that breakfast interferes with hygiene care, such as showers. She discussed that care is late due to working at breakfast. She discussed that meals often come late because nursing staff are attending to other job duties prior to breakfast such as residents' personal care. She stated because of giving care prior to breakfast, it often comes from approximately 10:00 AM to 10:30 AM. She discussed that lunch starts at 11:30 AM and thus residents do not have an adequate amount of time between meals. LNA #1 stated residents have made comments about low staffing. An interview was conducted with Resident #31's family representative on 7/17/25 at 10:20 AM. S/he stated Resident #31 does not always get the help he/she needs. S/he stated, 'They [the staff] tell us don't worry but the family representative was worrisome. S/he stated there was an issue with staffing. The family representative discussed that s/he is at the facility with Resident #31 a couple of hours a day and does not see staff repositioning the resident in wheelchair. The family representative stated an LNA stated to him/her 'I did a 14 hour shift today because I know that if I didn't stay, the elders on the floor wouldn't get the care they needed. The LNA also discusses they do not always have two staff available to operate the Hoyer lift. Per record review of grievances, Residents #3, #6 #9 #13 #15 #18 #35 and #42 wrote grievances for 6/3/25 that stated that two licensed nursing staff members refused to answer call lights the previous night. Resident #6's grievance says that they [the two licensed nursing staff members] stated, 'It's a rule to not help them [residents] at night. The residents continued to have concerns with staffing even after the grievances were filed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based upon observation and interview, the facility failed to ensure expired medications were stored or disposed of properly, and medications were secured. Findings include: Findings include: 1) On 07/15/2025 at 3:12 PM, two medications were observed to be expired in 1 of 3 medication carts. The medications were Docusate Sodium (a medication to alleviate constipation) 100 mg [milligram] tab which expired on 1/2025. The other medication was Guaifenesin (a medication used to alleviate coughing) 16 fl oz [ounce] with an expiration date of 5/2025. The nurse assigned to the med cart confirmed that both medications were expired. 2) Per review of the facility's policy titled Medication Storage Storage of Medication reviewed on 1/25, it states that Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized assess. Per review of the facility's policy titled Medication Administration General Guidelines reviewed on 1/25, it states During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications when unlocked. On 07/15/2025 at 10:51 AM, the medication treatment cart was observed to be unlocked. At 10:59 AM the Director of Nursing (DON) who was assigned to the medication cart confirmed that it should have been locked. On 07/16/2025 at 9:25 AM, a Registered Nurse (RN) was observed dropping a Senna pill (medication to help alleviate constipation) on her medication cart and then walking away to the other medication cart to get more Senna pills, leaving behind the Senna pill unattended along with a medication pack of Benzonatate 100 mg tablets (a medication used to help alleviate coughing). The RN then walked past the medications left out on the cart (the Senna pill and Benzonatate pack) to a resident's room. When the RN returned from giving medications she confirmed that she had left out the Senna pill on the medication cart and the whole packet of Benzonatate pills. On 7/17/2025 at 11:24 AM, the medication treatment cart directly in front of the nurses' station was observed to be unlocked and one of the drawers partially opened on A-Wing. There were three staff in the hallway and two self-propelling residents in the hallway, both with a diagnosis of dementia. At 11:31 AM, the nurse was approached whose medication treatment cart was unlocked. She confirmed that it should have been locked.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on record review and interview, the facility failed to obtain required consents and maintain accurate records regarding influenza and pneumococcal vaccines for 3 out of 5 residents [Residents #2, 15, 50]. Findings include: 1) Per record review of Resident #2's immunization records, Resident #2's representative declined having the administration of the influenza vaccine with the representative and the provider signing and dating the Influenza Vaccine Informed Consent document on 9/12/2024. On 10/10/2024, Resident #2 received the Influenza vaccination and there was no updated consent form in the Residents Electronic Health Records. 2) Per record review of Resident #15's immunization records, the Resident did not sign the pneumococcal vaccine form, nor was it indicated whether the Resident wished to receive the vaccination. The provider, however, did sign and date the form and it is dated 4/22/2025. 3) Per record review of Resident #50's immunization records, the Resident did not sign the pneumococcal vaccine form. A nurse signed where Resident #50 should have signed, and in the signature of a licensed nurse, the nurse had signed their name again. Per interview, it was confirmed by the DON on 7/17/2025 at 12:44 PM that Resident #2 did not have an Influenza vaccine consent form in the chart and that the pneumococcal vaccine for both Resident #15 and #50 was filled out incorrectly and needed to be updated.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>Based on record review and interview the facility failed to have a consent form for 1 [Resident 42] out of 5 residents for Covid-19 vaccination. Findings include:Per record review of Resident #42's immunization records, the Resident did not have a covid vaccine consent form.Per interview, on 7/17/2025 at 12:44 PM it was confirmed by the Director of Nursing (DON) that it wasn't completed and needed to be done.</p>		