VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

September 20, 2019

Ms. Rose Mary Mayhew, Administrator
Bel Aire Center
35 Bel-Aire Drive
Newport, VT 05855-4953

Dear Ms. Mayhew:

Enclosed is a copy of your acceptable plans of correction for the recertification survey completed on **August 28, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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 _____	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL AIRE CENTER	35 BEL-AIRE DRIVE NEWPORT, VT 05855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced onsite recertification survey with Emergency Preparedness review was conducted by the Division of Licensing and Protection from 8/26- 8/28/19. The facility was found in substantial compliance with regulations related to Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection from 8/26- 8/28/19. The following regulatory deficiency was identified.	F 000	Bel-Aire Center provides this plan of correction without admitting or denying the validity or existance of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rose Mary Mayhew | TITLE: CED | (X6) DATE: 9-19-19

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.

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive care plan for 2 of 15 applicable residents (Residents # 16 and #21). Findings include: 1. Resident # 16 has no care plan to address needs related to skin integrity. Resident # 16 has self-inflicted scratches his/her arms. Nursing notes back to 7/23/19 confirm this. Nursing notes from 8/13/19 and 8/24/19 state that the Resident scratches until h/she bleeds. On 8/27/19 at 9:13 AM, the Director Of Nurses stated that there should be a care plan to address these skin conditions and confirmed that there was no care plan in place to address needs related to skin integrity. 2. Resident #21 developed a pressure ulcer on their ankle 8/19/19. There was no update to the	F 656	F656 Resident # 16 and #21 careplans were reviewed and immediately revised 8/27/19. An audit was conducted of care plans for potential similar concerns. Nursing staff will be educated on the process to develop a comprehensive care plan Audits will conducted by the CNE and/or designee weekly x 3, then biweekly x 3 Results of audits will be reviewed at QAPI for further recommendations Discipline responsible - CNE or designee F656 POC accepted 9/19/19 Kcampos RN/PMC	9-24-19

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F 656	Continued From page 2	F 656		

resident's plan of care to indicate the development of a pressure ulcer and no interventions added to the care plan to list treatment or preventative measures.

3. Resident #21 was transferred to the hospital on 8/3/19 with a Urinary Tract Infection (UTI) and Pyelonephritis that required a 2 day hospital admission. Per review of the plan of care, there was no care plan area developed to address the UTI and Pyelonephritis with appropriate monitoring and interventions added after these events.
Per interview on 8/27/19 at 10:39 AM, the Director of Nursing confirmed that the care plan areas of Pressure Ulcers and UTI risk were not developed for Resident #21.