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 9, 2024

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 complaint investigation conducted on **August 12, 2024.** 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

Pamela M. Cota, RN
Licensing Chief

Enclosure

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 ______	C 08/12/2024

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
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation (#23163, #23185, #23186, #23189, and #23191) was conducted by the Division of Licensing and Protection on 8/12/24 at Bel Aire Center to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 000	This plan of correction is written to comply with state and federal guidelines It is not an admission of noncompliance. However, it is the facility commitment to demonstrate compliance.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rose Mary Mayhew
TITLE: Administrator
(X6) DATE: 9/6/2024

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 609	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to report allegations of abuse to the appropriate agencies and responsible parties in the required timeframes for 1 resident [Resident #1] of 4 sampled residents. Findings include: Per review of the facility's Abuse Prohibition Policy [revised 10/24/22]: - Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. - The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law - All reports of suspected abuse must also be reported to the patient's family and attending physician. -Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injury of unknown origin, or misappropriation of patient property must also report to outside agencies, if required. -Staff are obligated to report reasonable suspicion of a crime against the elderly to the state agency and local law enforcement. Administrators and Directors of Nursing must assist in reporting. Per record review, Licensed Nurse's Aide [LNA] #1 provided a witness statement on 7/19/24 regarding an incident that had occurred 4 days earlier on 7/15/24 involving Res.#1 and another LNA [LNA #2].	F 609		

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F 609	Continued From page 2 Per LNA #1's statement: ""I was working on A wing with [LNA #2] ... [LNA #2] did not ask [Res.#1] if [s/he] would like care done, instead [LNA #2] grabbed [Res.#1] by [h/her] arm and made [h/her] walk to the bathroom. [Res.#1] wanted to go to the sink to start, [LNA #2] grabbed [Res.#1] by [h/her] arm and attempted to force [h/her] to walk backwards toward the toilet. [LNA #2] also raised [h/her] voice at [Res.#1] when [s/he] did not cooperate. [Res.#1] said "ouch" and other things like "you're hurting me" multiple times ...I tried to speak softly to [Res.#1] as [s/he] asked questions like 'why were we trying to kill [h/her]' and why [h/her] daughter would put [h/her] in a place like this, although I really did not have much to say because I was in disbelief." LNA #1's statement continues with after witnessing the alleged resident abuse, "I couldn't find a nurse to report this incident to until much later and there was too much going on. The next day, while the Nurse Educator and I were talking, [s/he] asked me how the previous evening had went (working with [LNA #2]) and I told [h/her] about the incident and that I didn't really know the proper steps to take, and [s/he] told me that I can go online and make a report or that I could call a number to report it." Per review of facility records, the Nurse Educator did not report the abuse allegation to the facility's DON or Administrator [ADM] and did not follow up with LNA #1 to verify the allegation had been reported to the required agencies. An interview was conducted with the Director of Nursing [DON] on 8/12/24 at 10:19 AM. The DON reported [s/he] first became aware of abuse allegations on 7/18/24 when an Adult Protective Services investigator arrived at facility. The DON stated that the Abuse Procedure is to "immediately report to the charge nurse," if	F 609	F 609 Resident #1 did not have any negative effects due to the incident cited. All residents have the potential to be affected. The nurse who was the NPE (staff educator) who failed to report the incident no longer works at the facility. Staff have been reeducated on abuse, prevention, and dignity immediately after being made aware of the issue.These sessions occurred between 7/22/24 and 7/30/24. All staff completed a test 'Identifying Abuse and Reporting requirements' post education Abuse education is completed yearly by all newly hired staff prior to any direct contact with residents and yearly thereafter. Random interviews of staff will be conducted weekly by DON or designee x 4 weeks then monthly x 3 - results will be reported to QAPI Oversite by DON/Adm or designee **Tag F 609 POC accepted on 9/9/24 by T. Dougherty/P. Cota**	9/26/24

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F 609	Continued From page 3 charge nurse is not present, to call the DON day and night regardless. The DON stated the Nurse Educator 'absolutely should' have reported the abuse allegations after speaking with LNA #1 and informed the DON and Administrator [ADM] but did not. The DON stated there was "a disconnect" with following the proper procedure, and the Nurse Educator "dropped the ball". Per review of a report form received at the Division of Licensing and Protection on Thursday, July 18, 2024, at 2:22 PM, [3 days after the incident] the DON reported "Today at around noon Adult Protective Services showed up to Bel Aire Center after they received a report of a LNA [#2] yelling loudly and dragging resident [Res.#1] to the toilet ... There have been no reports in the building of anything like this, no documentation in the resident's chart of any situation". The DON confirmed that facility staff failed to report the allegation of abuse on 7/15/24 to the facility's DON, ADM, and the appropriate agencies and responsible parties in the required timeframes.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		

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F 610	Continued From page 4 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, in response to allegations of abuse the facility failed to Immediately investigate the allegations and to prevent further potential abuse for 1 resident [Resident #1] of 4 sampled residents. Findings include: Per review of the facility's Abuse Prohibition Policy [revised 10/24/22]: -Initiate an investigation within 24 hours of an allegation of abuse that focuses on: whether abuse or neglect occurred and to what extent. -The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. Per record review, Licensed Nurse's Aide [LNA] #1 provided a witness statement on 7/19/24 regarding an incident that had occurred 4 days earlier on 7/15/24 involving Res.#1 and another LNA [LNA #2]. Per LNA #1's statement: ""I was working on A wing with [LNA #2] ... [LNA #2] did not ask [Res.#1] if [s/he] would like care done, instead [LNA #2] grabbed [Res.#1] by [h/her] arm and made [h/her] walk to the bathroom. [Res.#1] wanted to go to the sink to start, [LNA #2] grabbed [Res.#1] by [h/her] arm and attempted to force [h/her] to walk backwards toward the toilet. [LNA #2] also raised [h/her] voice at [Res.#1] when [s/he] did not cooperate. [Res.#1] said	F 610	F610 Resident #1 did not have any negative effects due to the incident cited. All residents have the potential to be affected. The nurse who was the NPE (staff educator) who failed to report the incident no longer works at the facility. Staff have been reeducated on abuse, prevention, and dignity immediately after being made aware of the issue.These sessions occurred between 7/22/24 and 7/30/24. All staff completed a test 'Identifying Abuse and Reporting requirements' post education Abuse education is completed yearly by all newly hired staff prior to any direct contact with residents and yearly thereafter. Random interviews of staff will be conducted weekly by DON or designee x 4 weeks then monthly x 3 - results will be reported to QAPI Oversite by DON/Adm or designee	9/26/24

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F 610	Continued From page 5 "ouch" and other things like "you're hurting me" multiple times. ...I tried to speak softly to [Res.#1] as [s/he] asked questions like 'why were we trying to kill [h/her]' and why [h/her] daughter would put [h/her] in a place like this, although I really did not have much to say because I was in disbelief." LNA #1's statement continues with after witnessing the alleged resident abuse, "I couldn't find a nurse to report this incident to until much later and there was too much going on." LNA #1 stated that s/he reported the abuse allegation the next day during a conversation with the facility's Nurse Educator. Per review of facility records, the Nurse Educator did not report the abuse allegation to the facility's DON or Administrator [ADM] and did not follow up with LNA #1 to verify the allegation had been reported to the required agencies. An interview was conducted with the Director of Nursing [DON] on 8/12/24 at 10:19 AM. The DON reported [s/he] first became aware of abuse allegations on 7/18/24 when an Adult Protective Services investigator arrived at facility. Per review of a report form received at the Division of Licensing and Protection on Thursday, July 18, 2024, at 2:22 PM, [3 days after the incident] the DON reported "Today at around noon Adult Protective Services showed up to Bel Aire Center after they received a report of a LNA [#2] yelling loudly and dragging resident [Res.#1] to the toilet ... There have been no reports in the building of anything like this, no documentation in the resident's chart of any situation". The DON reported that it was after this occurred that the facility launched an investigation into the abuse allegation. Per record review, during the time of the witnessed alleged abuse, and the start of the investigation 3 days later on 7/18/24, LNA #2 was not immediately taken off duty or taken off the	F 610	**Tag F 610 POC accepted on 9/9/24 by T. Dougherty/P. Cota**	

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F 610	Continued From page 6 schedule after the incident on 7/15/24. Review of the facility's LNA schedule and LNA task record reveals that LNA #2 was assigned to and provided care to Res.#1 again on 7/17/24. The DON confirmed that an investigation into the abuse allegation should have been initiated immediately on 7/15/24 after the alleged event occurred, and that the staff member involved, LNA #2, should immediately have been taken off duty and taken off the schedule to prevent further potential abuse but was not.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 provide as a result of PASARR recommendations. If a facility disagrees with the	F 656	F 656 Resident #1 has no ill effects from this incident. All residents have the potential to be affected. Audit of Medication orders was done. Nursing staff have/will been reeducated on administering medications with parameters Random audits will be conducted weekly x4 then monthly x3 - results will be reported to QAPI Oversite by DON/Adm or designee **Tag F 656 POC accepted on 9/9/24 by T. Dougherty/P. Cota**	9/26/24

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F 656	Continued From page 7 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to implement care plan interventions regarding medications and physician orders for 1 resident [Res.#1] of 4 sampled residents. Findings include: Review of Res.#1's medical record reveals the resident was admitted to the facility on 7/5/24, with Physician Orders that included an order for 'Metoprolol: Give 1 tablet by mouth two times a day for blood pressure. Hold Metoprolol if Systolic Blood Pressure is less than 110 or Heart Rate is less than 65.' [Metoprolol is a medication that affects the heart and circulation and is used to treat angina (chest pain) and hypertension (high blood pressure)] (https://www.drugs.com/mtm/metoprolol-succinate-er.html)	F 656		

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F 656	Continued From page 8 [A blood pressure reading has two numbers. The top number is called the Systolic Blood Pressure. The top number measures the pressure in the arteries when the heart beats.] (https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/in-depth/blood-pressure) Review of Res.#1's Care Plan reveals the resident is identified as "exhibits or is at risk for cardiovascular symptoms or complications related to heart failure". Care Plan interventions include "Administer meds as ordered" Review of Res.#1's medical record and Medication Administration Record [MAR] beginning on 7/13/24 and continuing through the day of the complaint investigation on 8/12/24 reveals that Res.#1's Systolic Blood Pressure and/or Heart Rate were below the physician prescribed parameters 16 times, yet the blood pressure medicine Metoprolol was still administered. Further review reveals no documentation in Res.#1's medical record of why the medication was given in error or that the physician was notified of the medication order not being followed. An interview was conducted with the Director of Nursing [DON] on 8/12/24 at 10:19 AM. The DON confirmed that the Metoprolol medication order requires the medication to be held when below certain parameters, and despite the physician ordered parameters, the medication was not "administered as ordered" per the resident's Care Plan on 16 occasions between 7/13 and 8/12/24.	F 656		