



Department of Disabilities, Aging and
Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

August 25, 2025

Mr. Richard Barber, Administrator
Bel Aire Center
35 Bel-Aire Drive
Newport, VT 05855

Provider ID #: 475049

Dear Mr. Barber:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **July 17, 2025**. 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,

A handwritten signature in dark ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

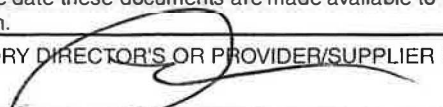
Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025
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NAME OF PROVIDER OR SUPPLIER Bel Aire Center	STREET ADDRESS, CITY, STATE, ZIP CODE 35 Bel-Aire Drive , Newport, Vermont, 05855
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(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
E0000	Initial Comments An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 7/15/25 to 7/17/25 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified regulatory violations.	E0000		
E0013 SS = C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this	E0013	E Tag 013 Development of EP Policies and Procedures On 7/24/25 The Emergency Plan was updated and the Annual review was completed. Admin will perform annual reviews of the Emergency plan as required. Admin will be notified by annual calendar and statewide notifications re: timely updates of the EP. Results of the EP will be presented to the monthly QAPI program for continued compliance as part of the portion designated for the Administrator. Date of Compliance: 8/28/2025 Tag E0013 POC accepted on 8/25/25 by T. Dougherty/S. Stem	8/28/2025

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 reverse for further 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 Administrator	(X6) DATE 8/11/25
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E0013 SS = C	Continued from page 1 section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the emergency preparedness policies and procedures were reviewed and updated at least annually. Findings include: An interview was conducted with the facility's Administrator [ADM] on 7/17/25 at 9:30 AM. The ADM confirmed that the most recent review of the facility's Emergency Preparedness Plan was dated 3/4/24 and did not meet the requirement of an annual review.	E0013		
E0030 SS = C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed	E0030		

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E0030 SS = C	Continued from page 2 and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following:	E0030	E Tag 030 Names and Contact Information On 7/24/25 The Emergency Plan was reviewed and the names and contact information was updated and changed as necessary. Admin will perform annual reviews of the Emergency plan as required. Admin will be notified by annual calendar and statewide notifications re: timely updates of the EP. Results of the EP will be presented to the monthly QAPI program for continued compliance as part of the portion designated for the Administrator. Date of Compliance: 8/28/2025 Tag E0030 POC accepted on 8/25/25 by T. Dougherty/S. Stem	8/28/2025

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E0030 SS = C	Continued from page 3 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).	E0030		

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E0030 SS = C	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure contact information for the Emergency Preparedness plan was accurate and up to date regarding current personnel. Findings include: An interview was conducted with the facility's Administrator [ADM] on 7/17/25 at 9:30 AM. The ADM confirmed that review of the facility's Emergency Preparedness Plan revealed contact information was absent for the current Administrator, Director of Nursing, Medical Director, Human Resources Designee and Area President of Operations.	E0030		
E0039 SS = C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional	E0039	E Tag 039 EP Testing Requirements On 7/23/25 a facility wide mock disaster drill was conducted by the Admin and the Maintenance Supervisor. The mock disaster drill was evaluated on 7/24/25 and found to be adequate. Admin will perform annual reviews of the Emergency plan as required. Admin will be notified by annual calendar and statewide notifications re: timely updates of the EP. Results of the EP will be presented to the monthly QAPI program for continued compliance as part of the portion designated for the Administrator. Date of Compliance: 8/28/2025 Tag E0039 POC accepted on 8/25/25 by T. Dougherty/S. Stem	8/28/2025

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E0039 SS = C	Continued from page 5 exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or			E0039			

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E0039 SS = C	Continued from page 6 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct	E0039		

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E0039 SS = C	Continued from page 7 exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the	E0039		

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E0039 SS = C	Continued from page 8 emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E0039		

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E0039 SS = C	Continued from page 9 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E0039		

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E0039 SS = C	Continued from page 10 plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360]	E0039		

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NAME OF PROVIDER OR SUPPLIER Bel Aire Center	STREET ADDRESS, CITY, STATE, ZIP CODE 35 Bel-Aire Drive , Newport, Vermont, 05855
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E0039 SS = C	Continued from page 11 (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCl must conduct exercises to test the emergency plan. The RNHCl must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCl's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure drills and emergency preparedness tests were conducted as required on an annual basis. Findings include: An interview was conducted with the facility's Administrator [ADM] on 7/17/25 at 9:30 AM. The ADM confirmed that review of the facility's Emergency Preparedness Plan revealed the most recent emergency preparedness exercise was conducted on 4/7/24 and did not meet the requirement of an annual test to ensure the viability of the emergency plan.	E0039		

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E0039 E0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of 3 complaints and 2 facility reported incidents, including reports #24205, 24206, 24108, 24152, 24216, from 7/15/25 through 7/17/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	E0039 F0000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law	8/28/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. 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, including those specified in this section. §483.10(a)(1) A facility must 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 his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of	F0550	F-550 Resident Rights The resident #4's Foley catheter cover bag was applied. Residents with indwelling catheters could be affected by this alleged deficient practice. All residents with indwelling catheters were inspected to confirm the proper cover was in place and all others were correct. The nursing staff will be educated on the practice of changing to the cover bag upon admission to ensure dignity. The DON and or designee will audit indwelling catheters weekly x4 and monthly x 3 to ensure compliance with use of the cover bag All audits will be reviewed at QAPI for further recommendations Date of Compliance: 8/28/2025 Tag F0550 POC accepted on 8/25/25 by T. Dougherty/S. Stem	

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F0550 SS = D	Continued from page 13 interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: 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,	F0550		

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F0550 SS = D	Continued from page 14 especially if I were in public."	F0550	F-689	
F0689 SS = E	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. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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. 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,	F0689	Free of accidents and hazards Resident # 25 plan of care was reviewed and revised and resident # 35 care plans were reviewed and revised to reflect updates after a fall. Other residents that have had a fall could be affected by this alleged deficient practice. A 30 day look back of falls/ care plans was conducted. Nursing staff will be re-educated on the requirement to update the plan of care immediately after a fall to help prevent recurrence. The interdisciplinary team will additionally review falls to determine root cause and additional interventions may be added to the care plan The Don and or designee will audit weekly x 4 and monthly x 3 to ensure compliance with updating the care plan after a fall. Audits will be reviewed at QAPI for further recommendations Date of Compliance: 8/28/2025	8/28/2025

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F0689 SS = E	Continued from page 15 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." 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." 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." 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...The patient [Resident #25], experienced a fall today, 07/12/2025. This fall resulted in a head	F0689	Tag F0689 POC accepted on 8/25/25 by T. Dougherty/S. Stem	

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F0689 SS = E	Continued from page 16 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]." 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. 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." 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." 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. Works Cited: Pleural Effusion. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/17373-pleural-effusion. Accessed 7/24/25. Transient Ischemic Attack. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/transient-ischemic-attack/symptoms-causes/syn-20355679. Accessed 7/22/25.	F0689		

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F0689 SS = E	Continued from page 17 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. 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." 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. 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.	F0689		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F0697		

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F0697 SS = D	Continued from page 18 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: 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	F0697	F-697 Pain management Resident #40 had their pain medication reviewed by the provider and revised. Other residents that use lidocaine pain patches could be affected by this alleged deficient practice. A review of lidocaine pain patches was completed and additional supply was obtained and will be kept in the med room Nursing staff will be re-educated on the process to follow when a medication is not available - notify the provider for guidance or new orders and communicate to nursing administration any unresolved medication supply issues. The DON/designee will audit the supply and use of lidocaine patches weekly x4 and monthly x 3 to ensure compliance of the patch as ordered. All audits will be reviewed at QAPI for further recommendations Date of Compliance: 8/28/2025 Tag F0697 POC accepted on 8/25/25 by T. Dougherty/S. Stem	8/28/2025

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F0697 SS = D	Continued from page 19 relieve the pain through non-pharmacological interventions.	F0697	F-725 Sufficient nursing staff	8/28/2025
F0725 SS = E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: 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	F0725	Residents ; #3,9, 13,15,4,6, 18,35,42, 40, and 5 the administrator and or DON met with individuals to review their concerns and reassure and discuss the improvements they are implementing and with the family of resident #31. The administrator attended the resident council and reviewed the survey and discussed proposed changes in meal delivery. The new social worker is introducing herself to the residents and families and making sure they are aware of the grievance process and encouraging communication The DON is interviewing and checking in with residents to ensure satisfaction is being achieved and maintained All residents could be affected by this alleged deficient practice. Call light audits are being performed to measure and ensure staff response is timely. A review of staffing is being done routinely several times per week. A recruitment call devoted to Belaire center occurs biweekly to work directly with the recruiter on the center needs.	

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(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
F0725 SS = E	Continued from page 20 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	F0725	Overtime is offered to cover some shifts and bonuses have also been used to show appreciation to staff that work additional hours. Travelers are used to fill positions when local staff cannot be obtained Employee appreciation is ongoing with recognition of leading with heart program, snacks, meals and gifts during recent nurses week, LNA week and ongoing staff engagement events The dining /meals process is being revised to a more standardized process while maintaining patient choice and engaging other departments in the process to improve efficiency in the meal delivery process. Center staff will be re-educated on the process for a more efficient meal delivery process The DON/designee will audit weekly 4 then monthly x 3 of the effectiveness of the changes with meal delivery as noted during staff and resident interviews and observation All audits will be reviewed at QAPI for further recommendations Date of Compliance: 8/28/2025 Tag F0725 POC accepted on 8/25/25 by T. Dougherty/S. Stem	

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F0725 SS = E	Continued from page 21 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.	F0725		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F0761		

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F0761 SS = E	Continued from page 22 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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	F0761	F-761 Label and store biologics No resident was affected by the alleged deficient practice. The carts were secured, meds put away and expired meds discarded. Residents could be affected by this alleged deficient practice if meds are not secured properly and expired med are not discarded. Nursing staff will be re -educated on the requirement to secure all meds and biologics and to observe for expiration dates and discard meds that are expired The DON/designee will audit the med carts, treatment carts and med room weekly x4 and monthly x 3 to ensure compliance of the labeling and storage of drugs and biologics All audits will be reviewed at QAPI for further recommendations Date of Compliance: 8/28/2025 Tag F0761 POC accepted on 8/25/25 by T. Dougherty/S. Stem	8/28/2025

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F0761 SS = E	Continued from page 23 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.	F0761		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F0883		

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F0883 SS = E	Continued from page 24 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: 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	F0883	F-883 Influenza and Pneumococcal Resident #2, #15, and #50 the consent form will be updated All Residents could be affected this alleged deficient practice An initial audit of all current residents for Influenza and Pneumococcal vaccine consent forms will be completed by DON/Designee Then all new residents will be reviewed after admission to ensure consents are completed and the vaccine is offered if indicated Nursing staff will be re- educated to complete the consent forms on admission and as needed and the importance of maintaining accurate records of influenza and pneumococcal vaccinations and consent for vaccines The DON/Designee will audit records for consent forms being obtained for the influenza and pneumococcal vaccine completed properly weekly x4 and monthly x 3 to ensure compliance. All audits will be reviewed at QAPI for further recommendations Date of Compliance: 8/28/2025 Tag F0883 POC accepted on 8/25/25 by T. Dougherty/S. Stem	8/28/2025

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F0883 SS = E	Continued from page 25 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.	F0883	F-887 covid vaccine Resident #42 the consent form will be updated All Residents could be affected this alleged deficient practice An initial audit of all current residents for covid covid vaccine consent forms will be completed Then all new residents will be reviewed after admission to ensure consents are completed and offered if indicated Nursing staff will be re- educated to complete the consent forms on admission and as needed and the importance of maintaining accurate records of covid vaccination consent of vaccines The don/ designee will audit records for consent forms being obtained for the covid vaccine completed properly weekly x4 and monthly x 3 to ensure compliance. All audits will be reviewed at QAPI for further recommendations Date of Compliance: 8/28/2025 Tag F0887 POC accepted on 8/25/25 by T. Dougherty/S. Stem	8/28/2025
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.	F0887		

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F0887 SS = D	Continued from page 26 (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: 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.	F0887		