



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

September 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 complaint investigation conducted on **September 2, 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

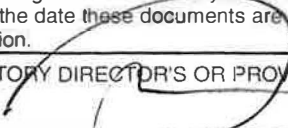
Enclosure

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 09/02/2025
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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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of one FRI (facility reported incident), including report #2600481, on 9/2/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000	F-760 RESIDENTS ARE FREE OF SIGNIFICANT MEDICATION ERRORS	9/26/25
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure one resident (Resident #1) of three sampled residents was free from significant medication errors which resulted in a resident developing DVT [Deep Vein Thrombosis] and being transferred to the emergency department. Findings include: Per record review of Resident #1's EMR [Electronic Medical Record] Resident #1 has diagnoses of a right femur fracture, muscle weakness, anxiety, and atrial fibrillation [a condition where the heart beats irregularly]. Resident #1 has a BIMS [Brief Interview of Mental Status] score of 7 as of 8/4/25, indicating Resident #1 has cognitive impairment. The resident is dependent on staff for ADLs [Activities of Daily Living] and hygiene. Per record review, Resident #1 was admitted to the hospital on 7/29/25 for a hip fracture and was discharged on 8/1/25. Per record review of Resident #1's discharge summary from the hospital on 8/1/25 contains a medication reconciliation section with the order "Enoxaparin 40 mg [milligram/ 0.4 mL [milliliter] injectable solution 0.4 milliliters subcutaneous (under the skin) every 24 hours for 30 days."	F0760	Resident #1 was transferred to the ER for evaluation immediately upon discovery of error and suspicion of DVT. DVT was confirmed, resident returned the same day with new anticoagulant therapy orders which were confirmed with the provider and transcribed correctly into the EHR/EMAR and initiated. The resident and her responsible party were notified of the error and the subsequent plan of care. This resident is being monitored for signs/symptoms of thromboembolic or bleeding complications. An adhoc QAPI meeting was held to discuss the medication error and plan. All residents could be affected by this alleged deficient practice An audit of all residents admitted or readmitted in the past 30 days with anticoagulant medication orders was conducted to ensure transcription accuracy. No other residents were found to have medication order discrepancies.	

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 Adnan	(X6) DATE 9/24/25
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F0760 SS = G	Continued from page 1 Per record review of Resident #1's August 2025 MAR [Medication Administration Record] Resident #1 was prescribed Enoxaparin Sodium Solution 40 mg [milligrams]/ 0.4 ml [milliliter]: Inject 40 mg subcutaneously one time a day for prevent blood clotting for 10 days." The order is written to start 8/2/25. She was administered the medication from 8/2/25 to 8/11/25. Three licensed nursing staff members administered this medication over the 10-day period. Per record review of the facility's "OPS424 Medication Reconciliation" policy [last revised 12/16/24] states, "3. For patients admitted from the hospital: 3.1 obtain and review copies of the Medication Administration Records (MARs), Treatment Administration Records (TARs), transfer forms, and Physician's Order Sheets (POS). 3.1.1 Verify MAR/TAR information with transfer forms and POS, if available....3 Clarify medication orders with clinical staff from transferring hospital, when necessary 5.4 Any discrepancies discovered during reconciliation will be reported to the physician/APP [Advanced Practice Physician] before finalizing the current list of medications." Per record review of Resident #1's progress note written by the NP [Nurse Practitioner] on 8/26/25 at 11:44 AM states, "Acute visit for DVT [Deep Vein Thrombosis] documented by ultrasound after ER [Emergency Room] transfer on 8/24 with reported 10 cm x 5.5 cm area of pain and redness which was enlarging. It was additionally noted that Lovenox [an injection that is used to help prevent blood clots] therapy was ordered for 30 days on discharge summary and given for 10 days; lapse of expected therapy for 12 days." Per record review of the ultrasound performed on 8/24/25 at the emergency department states, "Impression: There is superficial thrombophlebitis involving a subcutaneous vein in the anterior right thigh as well as the great saphenous vein at the saphenofemoral junction. The latter extends into the anterior aspect of the common femoral vein, as an equivalent to deep venous thrombosis..." An interview with the NP was conducted on 9/2/25 at 10:02 AM. The NP stated that the discharge order is checked when reconciling medication. She stated two nurses are supposed to check the order. She discussed she was called the morning of the visit to the emergency department visit by staff discussing the thigh swelling with a bruise type area. She stated, "This was a med [medication] error. This should not have happened."	F0760	Ongoing review of all residents currently receiving anticoagulants was completed to confirm correct dosage, duration of therapy, and monitoring were in place. All admission/readmission orders will require 2 nurse verification of order transcription accuracy. The pharmacist will also do a check of all admission/readmission orders for verification of transcription accuracy. All nurses were re-educated on the order transcription and verification processes and the importance of order accuracy. The DON/Designee will audit 100% of all admission/readmission orders for accuracy weekly times x4 and monthly x 3 to ensure compliance and corrective action will be taken if discrepancies are found. Results of audits will be reviewed in the QAPI meeting and plan of correction will be updated as deemed necessary. Tag F 760 POC accepted on 9/25/25 by C. Howard/S. Stem	

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F0760 SS = G	Continued from page 2 An interview was conducted with LPN [Licensed Practice Nurse] #1 on 9/2/25 at 10:09 AM. LPN#1 stated she transcribed the orders from the resident's discharge papers. She stated, "I did not hand off the check to the next person. I'm not sure if I should have. I wasn't alone that day but I'm not sure what happened. I don't know the process...[After the resident was sent to the hospital] They did an in-service education with a quiz...I still don't know the process. I'm trying to figure it out myself." An interview was conducted with the DON [Director of Nursing] on 9/2/25 at 10:50 AM. The DON stated, "Most days orders come in and unit clerk puts them in. She wasn't here that day. Then [the medication is] recheck [ed] from admitting nurse, checked again by a second time...The order was not checked a second time."	F0760		