



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

November 12, 2025

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

Provider ID #: 475049

Dear Mr. Stewart:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **October 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 10/17/2025
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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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of a facility reported incident (2635231) on 10/14/25 with offsite record review and interviews lasting through 10/17/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F0000		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F0604	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 facilities continued compliance with applicable law.	

A 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 11/10/2025
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F0604 SS = D	Continued from page 1 restraints. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that a resident was free from physical restraints for 1 of 1 applicable resident (Resident #2) related to a seat belt that the resident was unable to remove on their own. Findings include: Per record review, Resident #2 was admitted to the facility on 7/15/25 with diagnoses that include dementia, schizophrenia, and seizure disorder. Resident #2's admission Minimum Data Set (MDS; a comprehensive assessment) dated 7/18/25 indicates that s/he is dependent on staff for self-care and functional cognition and needs staff assistance for mobility. His/her cognitive skills for daily decision making are marked as "severely impaired." Resident #2's care plan's focuses include "Resident is at risk for falls: cognitive loss, lack of safety awareness, Impaired mobility," initiated on 7/16/25, and "Resident uses Seat Belt for safety and security," initiated on 7/16/25. Interventions include the use of a Velcro seat belt, initiated on 7/16/25. A "Restraint Evaluation/Reduction," was completed for Resident #2 on 7/16/25. It reads, "a restraint can only be used to treat a medical symptom and not to manage behavior, provide convenience, discipline or because of any specific diagnosis." The form indicates that the medical symptom is "dementia," and the restraint/device type is a "Velcro seat belt used as an enabler/reminder for safety." Per review of Risk Management System reports, Resident #2 had 4 unwitnessed falls in September 2025; 9/4/25, 9/6/25, 9/8/25, and 9/17/25. Reports indicate that on 9/17/25, Resident #2 "had gotten up from wheelchair unassisted and was walking and fell," suffered a laceration to his/her face, and was transferred to the Emergency Room. Per interview on 10/14/25 at approximately 11:00 AM, the Director of Nursing (DON) stated that there are no residents in the facility with a restraint. She explained that there are only two residents in the facility that use seat belts, one being Resident #2. Per observation on 10/14/25 at approximately 12:30 PM, Resident #2 was sitting by the nursing station in his/her wheelchair. S/He did not appear to have a belt	F0604	1. Corrective Action: Resident #2's buckle seat belt was immediately removed on 10/14/25. The Physician and representative were notified and order discontinued. 2. Residents using seat belts or positioning devices were reviewed. No other residents were found to have an unauthorized restraint. 3. Restraint policy reviewed and re-education provided to all clinical staff. 4. Monitoring: DON or designee will audit residents with seat belts weekly for four weeks, then monthly for three months. Results reviewed in QAPI. 5. Responsible Party: Director of Nursing/Designee 6. Completion Date: 11/19/2025 Tag F0604 POC accepted on 11/12/25 by S. Stem	

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F0604 SS = D	Continued from page 2 on his/her chair. Per interview on 10/14/25 at 12:38 PM, Licensed Practical Nurse #1 (LPN) explained that Resident #2 wears a seat belt all the time. The LNAs (licensed nursing assistants) are supposed to document in the Kardex (LNA documentation system) when it is used and licensed nurses should evaluate Resident #2's ability to remove the belt every shift. Per interview on 10/14/25 at 12:40 PM, LPN #2 stated that she was Resident #2's nurse for the day but is new to working with Resident #2. S/he was unsure if Resident #2 should be wearing a seat belt while in the chair. LPN #2 was observed to check Resident #2 for a seat belt and confirmed that s/he was sitting in the wheelchair without a seat belt on. Per interview on 10/14/25 at 12:42 PM, the Unit Manager stated that Resident #2 should have a seat belt on at all times when sitting in their wheelchair. In a follow up interview at 1:24 PM, the Unit Manager explained that the DON had asked her to take the seat belt off from Resident #2's wheelchair today because Resident #2 was unable to remove it on his/her own. Per interview on 10/14/25 at 1:26 PM, the DON stated that Resident #2 is not cognitively able to remove the seat belt on command. The DON confirmed that Resident #2 had a buckle seat belt on as of today and was unable to provide any information as to when s/he was switched from a Velcro belt to a buckle seat belt. Per interview on 10/14/25 at 1:35 PM, the Nurse Practitioner stated that Resident #2 used a seat belt for fall prevention and was not cognitively able to remove the seat belt on command. The NP confirmed that Resident #2's buckle seat belt would be considered a restraint. Per phone interview on 10/15/25 at 3:17 PM, Resident #2's Representative explained that Resident #2 used to have a Velcro seat belt, but it was changed to a seat belt with a button after his/her last fall. The Representative doesn't remember the facility letting him/her know of the change or getting consent for that change but had noticed a change after a visit with Resident #2 after their last fall. The Representative explained that the seat belt was used to prevent Resident #2 from falling. Per record review, Resident #2 does not have a physician order for a buckled seat belt that specifies a medical symptom, frequency of use and release time,	F0604		

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F0604 SS = D	Continued from page 3 and activities to be performed during release. Resident #2's care plan was updated on 9/30/25 to remove the use of a Velcro seat belt and change to "seat belt." Resident #2's medical record, including their care plan, does not include documentation of how the use of the seat belt would treat a medical symptom that warrants the use of restraints, the type of direct monitoring and supervision that will be provided during use of the restraint, recommendations for gradual reduction, or address any risks related to the use of the restraint. There is no evidence that consent was obtained for the use of a buckle seat belt. There is no evidence of completed restraint assessments after the initial evaluation completed on 7/16/25. Per a virtual interview on 10/17/25 at 9:30 AM, the DON was unable to determine who or when Resident #2's Velcro seat belt was changed to a buckle seat belt. The DON confirmed that the restraint policy was not followed for Resident #2 because his/her seat belt was not considered a restraint. Facility policy titled "NSG233 Restraints: Use of," revised 9/15/25, reads, "Patients have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the patient's medical symptoms... Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of restraints. Physical restraint refers to any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: · Is attached or adjacent to the patient's body, · Cannot be removed easily by the patient, and · Restricts the patient's freedom of movement or normal access to their body. Removes Easily means that the manual method, physical or mechanical device, equipment, or material can be removed intentionally by the patient in the same manner as it was applied by staff. 3.1 The Center will determine the presence of a specific medical symptom that would require the use of restraints and determine: 3.1.1 How the use of restraints would treat the medical symptoms;	F0604		

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F0604 SS = D	Continued from page 4 3.1.2 The length of time the restraint is anticipated to be used to treat the medical symptoms, who may apply the restraint, and the time and frequency that the restraint will be released; 3.1.3 The type of direct monitoring and supervision that will be provided during use of the restraint; 5. Obtain physician/advanced practice provider (APP) order specifying: 5.1 Type of device; 5.2 Specific medical symptom; 5.3 Frequency of use and release time (NOTE: PRN orders are not acceptable); 5.4 Activities to be performed during release. 6. Patients with the restraint will be reassessed monthly for three months, then quarterly and with any significant change in condition or in accordance with state regulations. 8. Consent must be obtained prior to the application of the restraint. The patient, or the patient representative if applicable, has the right to refuse the use of a restraint and may withdraw consent to use the restraint at anytime. Refusal must be documented in the medical record. 10. Develop a plan of care for the use of the restraint. The care plan should be updated accordingly to include the development and implementation of interventions, recommendations for gradual reduction and address any risks related to the use of the restraint."	F0604		
0689 S = G	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.	F0689	1. Resident #1's broken seat belt was replaced 10/14/25; Resident #3 no longer resides at the center. Resident #2 care plan continues to be reviewed and updated with fall prevention interventions.	

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F0689 SS = G	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure residents remained as free from accidents as possible related to falls for 3 of 3 sampled residents (Residents #1, #2, and #3) by failing to ensure assistive devices functioned properly, provide adequate supervision, and create and implement effective, timely interventions that would reduce the likelihood of future falls. As a result, Resident #1 suffered a fall that resulted in pain, a fractured nose, a left humerus (upper arm bone) fracture, and rib fractures. This is a repeat deficiency for this facility, with the violations cited during the previous recertification survey dated 7/17/25. Findings include: 1. Per record review, Resident #1's care plan reveals that s/he needs assistance or is dependent on staff to perform activities of daily living (ADLs) and uses a wheelchair. His/her care plan includes the focus "[Resident #1] is at risk for falls related to hx [history] of falls, poor safety awareness, unsteady gait," created on 2/10/22, including an intervention for "Seat belt w/c [wheelchair] for fall reminder Monitor for safe use of belt Anti lock breaks on w/c," revised on 4/14/25. Physician orders include, "Resident may use seat belt in w/c as [s/he] tolerates if resident can demonstrate safe use," start date of 11/4/22, and "Assist resident qshift [every shift] when up in w/c with seat belt use," start date of 11/4/22. Regular progress notes reveal that Resident #1 can demonstrate removing the seat belt easily. Resident #1 has a BIMS (Brief Interview for Mental Status) of 10 as of 9/25/25 indicating moderate cognitive impairment. A Risk Management System (RMS) report of an unwitnessed fall dated 10/3/25 reads, "Resident found on the floor laying on [his/her] right side, with foot under wheelchair, laying on [his/her] right arm, blood on the floor next to the resident's face, nosebleed from right nostril, hematoma to right forehead, laying in the hallway in front of [his/her] room door. Resident's seat belt on [his/her] wheelchair was loose." The report indicated that Resident #1 complained of 6 out of 10 pain and was sent to the ER (emergency room) for evaluation and treatment. A 10/7/25 Nurse Practitioner (NP) note describes that Resident #1 suffered nasal, humerus, and rib fractures, and "is staying more in [his/her] room due to embarrassment of [his/her] facial bruising and need for more assistance...Slightly anxious affect, self-conscious about [his/her] facial bruising."	F0689	2. Residents of the center have the potential to be affected by cited deficient practice. Facility-wide audit completed to ensure any noted similar device was functional and care plans current. No additional issues found. Residents at risk for falls continue to have fall risk care plans reviewed to ensure interventions related to fall prevention are in place as appropriate. Staff have been re-educated on proper procedure for malfunctioning equipment and Accidents/Incidents OPS 100 to include implementation and revision of care plans 3. Maintenance staff and nurses re-educated on reporting equipment issues in TELS. Paper log discontinued IDT continues to review falls to ensure the plan of care has been updated with appropriate interventions. .	

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F0689 SS = G	Continued from page 6 Per record review, nursing notes show that Resident #1 reported 7 out of 10 multiple times between 10/3/25 through 10/15/25. Per interview and observation on 10/14/25 at 10:00 AM, Resident #1 was in the dining room, in his/her wheelchair. When asked about his/her current wheelchair and seat belt, s/he explained that s/he just got a new wheelchair moments ago and the one s/he is in doesn't have a seat belt (for which s/he is care planned for to prevent falls). S/he said s/he has had a seat belt for a long time because it reminds him/her not to stand up on his/her own. When asked about his/her most recent fall, s/he explained that s/he fell on 10/3/25 because s/he was trying to reach for something on the ground. S/he said the seat belt had been broken for a few days and it wasn't tight around his/her waste like normal, so when s/he reached down, the belt wasn't tight enough to reminder him/her not to get up, s/he fell, and the wheelchair tipped over on him/her. S/he explained that staff were not around when this happened. S/He explained that his/her face, head, arm, and ribs were injured from the fall, and it is painful. Resident #1 is noted to have bruising under both eyes, their left arm is in a sling, and s/he grimaced in pain when moving. Per phone interview with Resident #1's Representative on 10/14/25 at 2:30 PM, s/he explained that a staff informed him/her that Resident #1's belt was broken on 10/1/25. The Representative stated that the end of the belt had been tied, as the belt clip was broken and could not be repaired, and that the belt remained loose in this state. Per interview with the Nurse Practitioner (NP) on 10/14/25 at 1:35 PM, she revealed she was aware that Resident #1's seat belt had been tied on after it had been found damaged. She confirmed that Resident #1's seat belt did not function properly the day s/he fell. S/He said the belt was loose enough not to work as a reminder but tight enough to take the chair with them when they fell. Per interview with the Maintenance Director on 10/14/25 at 1:50 PM, he stated that nursing staff had notified him that Resident #1's seat belt was broken, and upon examining the belt to confirm it was broken, he informed nursing staff that he could not fix it. The Maintenance Director stated that nursing staff told him they "would just tie it on." He explained that he ordered a new belt after he was notified that it was broken but it had not come in. He explained that the	F0689	4. Administrator/Designee to monitor use of TELS weekly x4, then Monthly x3. IDT to review fall incidents weekly x4, then monthly x3. The results of the audits will be reviewed in QAPI for further review and or recommendations. reviewed in QAPI. 5. Responsible Party: Administrator, Maintenance Director and DON. 6. Completion Date: 11/19/2025 Tag F0689 POC accepted on 11/12/25 by S. Stem	

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F0689 SS = G	Continued from page 7 order was never processed because the facility had been "cut off" and the account had been closed but he was never notified that it did not go through. The Maintenance Director explained that a paper maintenance log at the nursing station is used to track needed repairs instead of the facility's TELS electronic system, because "the girls just won't use" TELS. The Maintenance Director was unable to produce the paper maintenance logs for the period prior to 10/14/25 because the logs are thrown out when completed. When asked about the current status of the belt, he explained that he just put a new belt on Resident #1's wheelchair today (10/14/25) that was taken from another resident's chair this morning. Facility policy titled "PM100 The Equipment Life Cycle System (TELS): Use of, APPLICATION: Entire Company," revised 01/08/24 states, "Centers and Senior Living Communities will use The Equipment Life Cycle System (TELS) to document maintenance of all equipment, including medical equipment, located at the service location. Data entry into TELS is the responsibility of the Maintenance Department." Per telephone interview with the Administrator on 10/14/25 at 2:44 PM, he explained that the team discusses broken equipment in morning meeting. He could not recall the last time it was discussed as a team that Resident #1's belt was broken. He confirmed that repairs should be entered in and tracked in TELS. Per record review, Resident #1 did not have any new interventions in their care plan following staff's knowledge of the broken seat belt and following his/her fall on 10/3/25. While the care plan was updated on 10/3/25 to include "Resident seat belt Assessed each shift for looseness and dislodged," this intervention had already been in place since 11/4/22, as per physician orders. 2. Per record review, Resident #3 was admitted to the facility on 7/11/25 with diagnoses that include mild dementia, history of falls, and benign prostatic hyperplasia (enlarged prostate that causes urinary problems, including frequent urination at night). Resident #3's admission Minimum Data Set (MDS; a comprehensive assessment) dated 7/14/25 reveals that Resident #3 requires moderate to maximal staff assistance for mobility, including ambulation and toileting. Resident #3's care plan focuses include "Resident is at risk for falls: CVA [stroke], Impaired mobility,"	F0689		

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F0689 SS = G	Continued from page 8 created on 7/11/25, and "Resident is incontinent of urine with potential for improved control or management of urinary elimination. Dementia," created on 7/14/25. Interventions include "Encourage resident to use toilet upon awakening, after meals, nightly and PRN [as needed]," created on 7/14/25, and "Check and change upon rising/ac [before meals]/PC[after meals]/ and prn," created on 7/14/25. Per review of Risk Management System reports, Resident #3 had 9 unwitnessed falls from admission through 8/16/25. The is no evidence that care plan interventions for falls were developed, implemented, documented, or monitored for the following falls, based on the Risk management reports, progress notes, care plans, and Licensed Nursing Assistant point of care documentation for the following falls: On 7/23/25, Resident #3 had an unwitnessed fall in his/her room. Resident #3 reported to be trying to close the window. The care plan was not updated until 8/20/25, 28 days after the fall with "Place resident in high traffic areas when awake and confused." On 7/31/25, Resident #3 had an unwitnessed fall in his/her room, resulting in a skin tear to his/her right hand. Resident #3 reported to be trying to go to the bathroom. The care plan was not updated until 8/20/25, 20 days after the fall with "Offer toileting assistance to resident before and after meals, before bedtime, and between 10:30pm-11:30pm." On 8/6/25, Resident #3 had an unwitnessed fall in his/her room. Staff document "Resident needs assistance with walking, forgets [s/he] can't do it by [him/herself]." The care plan was not updated until 8/20/25, 14 days after the fall with "Place bed in low position when in bed." On 8/7/25, Resident #3 had an unwitnessed fall in his/her room. Resident #3 reported that s/he "was going to the bathroom and hit my face on the foot board." Resident #3 stated their pain was 2/10. "Resident has a history of falls. [S/He] has been educated to use the call light for assistance before getting up unassisted and was able to demonstrate activation of the call light but [s/he] is forgetful and does not remember to use the call light. [His/Her] balance is an issue and is noted to lean far right when standing." Later that evening on 8/7/25, Resident #3 had an unwitnessed fall in his/her room and was found with an open area to right forehead and reported 7 out of 10 pain. Resident	F0689		

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F0689 SS = G	Continued from page 9 #3 was sent to the Emergency Room. The care plan was not updated until 8/20/25, 13 days after these two falls with "Offer toileting every 2 hours while awake on odd hours." On 8/15/25, Resident #3 had an unwitnessed fall in his/her room. Resident #3 reported that s/he "was going pee and lost my balance." There are no new interventions following this fall. On 8/16/25, Resident #3 had an unwitnessed fall in his/her room. There are no new interventions following this fall until 8/20/25, 4 days after the fall when Resident #3 was moved to a new room closer to the nursing station. Per a virtual interview on 10/17/25 at 9:30 AM, the DON explained that a resident's care plan should be updated by the floor nurse during the shift that the resident fell. She confirmed that Resident #3's care plan was not updated after each fall with the new interventions until 8/20/25 following many of the above falls. She was unable to provide evidence that the interventions were implemented, documented, or monitored prior to 8/20/25. 3. Per record review, Resident #2 was admitted to the facility on 7/15/25 with diagnoses that include dementia, schizophrenia, and seizure disorder. Resident #2's admission Minimum Data Set (MDS; a comprehensive assessment) dated 7/18/25 indicates that s/he is dependent on staff for self-care and functional cognition and needs staff assistance for mobility. His/her cognitive skills for daily decision making are marked as "severely impaired." Resident #2's care plan's focuses include "Resident is at risk for falls: cognitive loss, lack of safety awareness, Impaired mobility," initiated on 7/16/25, and "Resident is incontinent of urine and is unable to cognitively participate in a retraining program due to cognitive loss," created on 7/16/25, with an intervention to "Check and change upon rising, ac, PC, hs [at bedtime] and prn," created on 7/16/25. Per review of Risk Management System (RMS) reports, Resident #2 had 4 unwitnessed falls in September 2025; 9/4/25, 9/6/25, 9/8/25, and 9/17/25. Reports indicated that on 9/17/25 Resident #2 "had gotten up from wheelchair unassisted and was walking and fell," suffered a laceration to his/her face, and was transferred to the Emergency Room.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLE 10/17/2025
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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) COMPLETI DATE
F0689 SS = G	Continued from page 10 Per a 9/4/25 RMS report, on 9/4/25, Resident #2 had an unwitnessed fall in the living room out of his/her wheelchair. Staff report that "Resident fell after getting up from [his/her] wheelchair unassisted and attempting to walk. [S/He] was found to be experiencing increased fidgeting and had been incontinent. Toileting before and after meals and at HS added to POC [point of care; LNA documentation] to try and reduce the risk of additional falls." This intervention was added to the care plan on 9/4/25 but is not new as it is a repeat intervention from 7/16/25. An intervention was added on 9/5/25 to "Keep in higher traffic areas when up to wheelchair." Per a 9/8/25 RMS report, on 9/8/25, Resident #2 had an unwitnessed fall in the living room out of his/her wheelchair. Staff report Resident #2 "should have been in a higher traffic area due to history of getting up unattended." Per a 9/17/25 RMS report, Resident #2 was left unattended in the living room again and had an unwitnessed fall in the living room resulting in a "laceration to the left side of face," and was transferred to ER. Staff report that s/he "had gotten up from wheelchair unassisted and was walking and fell." There was no new intervention to prevent falls created after this fall. Per a virtual interview on 10/17/25 at 9:30 AM, the DON confirmed that Resident #2's care plan was only updated to reflect a medical review after the 9/17/25 fall.	F0689		