

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 21, 2016

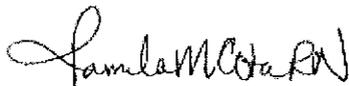
Ms. Rose Mary Mayhew, Administrator
Belaire Quality Center
35 Bel-Aire Drive
Newport, VT 05855-4953

Dear Ms. Mayhew:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 21, 2016**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/21/2016
NAME OF PROVIDER OR SUPPLIER BELAIRE QUALITY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 35 BEL-AIRE DRIVE NEWPORT, VT 05855	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Bel-Aire Center is filing this plan of correction, it 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.	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow professional standards of quality to ensure that treatments and/or assessments were documented as being completed for 3 of 14 residents (Residents #28, #33, #84). Findings include:</p> <p>1. Per record review, Resident #33 was prescribed a treatment by the physician on 4/6/16 for "Ciclopirix 8% Solution- IE Penlac. Apply Topically to affected nails every day-Fungus Tx", and also "Clotrimazole 1% Cream- IE Lotrimin/Mycelex Cr.. Apply topically to affected nails every day". On the treatment sheet, it indicated that the day shift was to apply the cream, and the evening shift to apply the solution treatment. In April and May 2016, the treatment sheet was filled out daily with very few missing initials. Starting with the June treatment sheet, the treatment was not signed off at all,, also not at all on the July or August treatment sheets, until it was discontinued by the physician in early August. The order was in place during</p>	F 281	<p>F-281</p> <p>For resident #3 the medication was Discontinued 8/12/16 No other Residents were negatively impacted by the alleged deficient practice. Treatments will be reviewed for Usage and correct documentation. For resident #84 a central line Documentation protocol sheet was Initiated 9/21/16 and appropriate Assessment and documentation was completed. No other residents were negatively affected by this alleged deficient practice. Other residents have the potential to be affected by the alleged deficient practices. An audit was conducted to ensure Any current resident with central line Care has the protocol sheet in use.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Rosemary M. ...* TITLE: *Center Executive Director* (X6) DATE: *10/17/16*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>that time period. Per interview on 9/20/16 at 2:45 PM, the Director of Nursing confirmed that this was an active order from April to August, and that staff did not document provision of this treatment as listed above.</p> <p>2. Per record review, Resident #84 was admitted on 9/14/16 from the hospital, with a recently placed Central Venous Catheter (CVC) for dialysis access. According to nursing staff, the Dialysis center is managing the CVC and they were not to do any flushes, just to monitor the site, and know the emergency procedures if there was problem with the catheter. Per the facility's policy, nursing is supposed to assess and document every shift on the catheter location, site appearance, security of clamps, and assessment of dressing. Per review of the nursing progress notes, there was no documented evidence that nursing was monitoring the Central Venous Catheter site per the policy. Resident #84 stated that the facility nurses were looking at the CVC site frequently, and that they change the dressing at the dialysis center. Per interview on 9/21/16 at 10:45 AM, the Director of Nursing confirmed that there was no documentation that nursing was assessing the site every shift per facility policy.</p> <p>3. Per record review, staff failed to check Resident # 28's oxygen saturation (O2 sat) levels as ordered by the physician. There is a physician order last signed 4/13/16 and continued on unsigned printed orders to check O2 sats every shift. Per review of the Medication Administration Record (MAR), there is no documentation that staff checked O2 sats on 53 occasions between</p>	F 281	<p>For resident #28 new orders for oxygen were obtained. No other resident was negatively affected. An audit was completed to review orders for Oxygen and ensure they have been assessed and documented as ordered. Nursing staff will be educated on Standards of professional assessment And documentation related to Provision of nursing care related to Treatments, central line care and Oxygen.</p> <p>CNE and or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QAPI meeting for further review and recommendations. Date of compliance: 10-21-2016</p> <p><i>F281 POC accepted Karen Campo RN</i></p>	<i>10/20/16</i>

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F 281	Continued From page 2 5/1/16 - 8/31/16. On 09/19/2016 at 4:19 PM, the Director of Nurses (DNS) confirmed that O2 sats are not being done as ordered by the physician. The DNS also confirmed staff should be checking and documenting O2 sats every shift as per MD order.	F 281		
F 282 SS=D	Reference: Lippincott Manual of Nursing Practice (9th) edition Wolters Kluwer Health/Lippincott Williams & Wilkins 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to implement the plan of care for 2 of 14 applicable residents in the stage 2 sample (Resident #5 and Resident #50). Findings include: 1). Per record review, staff did not draw labs as per the plan of care. Resident #5 has a care plan for Diabetes with an intervention stating "labs as ordered and report results to MD". There is also a care plan for risk for injury or complications related to the use of anticoagulation therapy medication with an intervention stating "Labs as ordered". The physician order was for Complete Blood Count (CBC), Renal Panel, Hemoglobin A1C (HbA1C), iron every 3 months and Liver	F 282	F-282 For resident #5 Lab work was drawn per plan of care 9/20/16 with no abnormalities noted. For resident #50 care plan was reviewed And re-education of staff occurred 9/12 And 9/23/16. No other residents were negatively Impacted by the alleged deficient practice. Other residents have the potential to be affected by the alleged deficient practice. Audits to ensure that care plan is being Implemented as intended related to	

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F 282	<p>Continued From page 3</p> <p>Function Test (LFT) every 6 months. Review of the clinical record showed that the last lab draw was done on 2/16/16. Labs should have been drawn for CBC, HbA1c and iron in May and August 2016 and LFT in August 2016. On 09/20/2016 at 1:57:01 PM the DNS confirmed labs had no been not done per physician orders or the care plan.</p> <p>2). Per record review Resident #50 (R#50) was care planned to have "Assist...with ambulation providing 1 assist, gait belt, and rolling walker in the hallways and encourage him/her to ask for assistance when s/he is in his/her room." On 9/10/16 at 3:20 PM R#50 fell while ambulating in the hallway with a Licensed Nursing Assistant (LNA) walking a few steps ahead of him/her according to the report. The LNA turned around and saw the resident stop and bend over to pick up something off the floor. The Kardex for the LNAs does state that the resident is a 1 assist with gait belt and rolling walker when ambulating in the hallway. The comprehensive care plan also states that the resident requires assist of 1 with a gait belt and rolling walker.</p> <p>In an interview at 1:30 PM the Facility Administrator confirmed that the resident was walking in the hallway without assistance but within the sight of staff. The Evening LNA staff were re-educated regarding following the Kardex and providing care listed in the Kardex. The Administrator confirmed that the resident should have had a staff member assisting him/her to ambulate with a gait belt and the rolling walker and that s/he was ambulating in the hallway independently.</p>	F 282	<p>Lab work and ambulation status will be Completed.</p> <p>Nursing staff will be educated on proper policy and procedure for ensuring the care is implemented per plan of care.</p> <p>CNE or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QAPI meeting for further review and recommendations.</p> <p>Date of compliance: 10-21-2016</p> <p><i>F282 POC accepted 10/20/16 Karen Campos RN</i></p>	

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F 282	Continued From page 4	F 282			
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that each resident received adequate supervision to prevent accidents for one resident (Resident #50). Findings include:</p> <p>Per record review Resident #50 (R#50) was care planned to have "Assist...with ambulation providing 1 assist, gait belt, and rolling walker in the hallways and encourage him/her to ask for assistance when s/he is in his/her room." On 9/10/16 at 3:20 PM R#50 fell while ambulating in the hallway with a Licensed Nursing Assistant (LNA) walking a few steps ahead of him/her according to the report. The LNA turned around and saw the resident stop and bend over to pick up something off the floor. The Kardex for the LNAs does state that the resident is a 1 assist with gait belt and rolling walker when ambulating in the hallway. The comprehensive care plan</p>	F 323	<p>F-323</p> <p>For Resident #50 there was no Injury. The care plan was reviewed and re-education of staff occurred 9/12/16 and 9/23/16. Other residents could be affected by This alleged deficient practice. An audit of ambulatory status Was conducted and reviewed with Staff. Care plans will be reviewed routinely and updated as changes occur. Nursing staff will be educated on the Process of communicating changes in Resident ability to ensure proper Supervision and prevention of accident. CNE or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QAPI</p>		

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F 323	Continued From page 5 also states that the resident requires assist of 1 with a gait belt and rolling walker. In an interview at 1:30 PM the Facility Administrator confirmed that the resident was walking in the hallway without assistance but within the sight of staff. The Evening LNA staff were re-educated regarding following the Kardex and providing care listed in the Kardex. The Administrator confirmed that the resident should have had a staff member assisting him/her to ambulate with a gait belt and the rolling walker and that s/he was ambulating in the hallway independently.	F 323	meeting for further review and recommendations. Date of compliance: 10-21-2016 <i>F323 POC accepted 10/20/16 Karen Campos RN</i>	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F-329 For resident #5 Labs were drawn on 9/20/16 as ordered with no abnormalities noted. All current resident charts were reviewed for Lab orders. A system was revised to track lab work. New admits will be added to the tracking system. Nursing staff will be re-educated on the procedure to ensure lab work is completed to monitor medications. CNE or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QAPI meeting for further review and recommendations. Date of compliance: 10-21-2016	

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F 329	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to adequately monitor medications for 1 of 14 applicable residents in the stage 2 sample (Resident # 5). Findings include: Per record review, staff did not draw labs as per the plan of care. Resident # 5 has a care plan for Diabetes with an intervention stating "labs as ordered and report results to MD". There is also a care plan for risk for injury or complications related to the use of anticoagulation therapy medication with an intervention stating " Labs as ordered". The physician order was for Complete Blood Count (CBC), Renal Panel, Hemoglobin A1C (HbA1C), iron every 3 months and Liver Function Test (LFT) every 6 months. Review of the clinical record showed that the last lab draw was done on 2/16/16. Labs should have been drawn for CBC, HbA1c and iron in May and August 2016 and LFT in August 2016. On 09/20/2016 at 1:57:01 PM the DNS confirmed labs had no been not done per physician orders or the care plan.	F 329	<i>F 329 POC accepted Karen Campos RN</i>	10/20/16
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		

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F 428	Continued From page 7 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the consultant pharmacist failed to report any irregularities to the attending physician and the Director of Nursing (DNS) for 1 of 14 applicable residents in the stage 2 sample (Resident # 5). Findings include: Per record review, staff did not draw labs as per MD orders and the plan of care, and the consultant pharmacist did not report these irregularities to staff. Resident # 5 has a care plan for Diabetes with an intervention stating "labs as ordered and report results to MD". There is also a care Plan for risk for injury or complications related to the use of anticoagulation therapy medication with an intervention stating " Labs as ordered". The physician order was for Complete Blood Count (CBC), Renal Panel, Hemoglobin A1C (HbA1C), iron every 3 months and Liver Function Test (LFT) every 6 months. Review of the clinical record showed that the last lab draw was done on 2/16/16. Labs should have been drawn for CBC, HbA1c and iron in May and August 2016 and LFT in August 2016. The clinical record showed the consultant pharmacist reviewed the record every month in 2016. On 09/20/2016 at 1:57 PM, the DNS confirmed labs had not been done per physician orders or per the care plan and that the consultant pharmacist did not report these	F 428	F-428 For resident #5 Labs were drawn on 9/20/16 as ordered with no abnormalities noted. All current resident charts were reviewed for Lab orders. A system was revised to track lab work. New admits will be added to the tracking system. Nursing staff will be re-educated on the procedure to ensure lab work is completed to monitor medications. The pharmacist will review records Monthly and report any irregularities to the attending physician and CNE per monthly written report. CNE or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QAPI meeting for further review and recommendations. Date of compliance: 10-21-2016 <i>F428 POC accepted 10/20/16 Karen Campor RA</i>	

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F 428 F 514 SS=E	Continued From page 8 irregularities to staff. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that treatments and/or assessments were documented as being completed for 3 of 14 residents (Residents #28, #33, #84). Findings include: 1. Per record review, Resident #33 was prescribed a treatment on 4/6/16 for "Ciclopirix 8% Solution- IE Penlac. Apply Topically to affected nails every day-Fungus Tx", and also "Clotrimazole 1% Cream- IE Lotrimin/Mycelex Cr.. Apply topically to affected nails every day". On the treatment sheet, it indicated that the day shift was to apply the cream, and the evening shift to apply the solution treatment. In April and May 2016, the treatment sheet was filled out daily with very few missing initials. Starting with	F 428 F 514	F-514 For resident #3 the medication was Discontinued 8/12/16 No other Residents were negatively impacted by the alleged deficient practice. Treatments will be reviewed for Usage and correct documentation. For resident #84 a central line Documentation protocol sheet was Initiated 9/21/16 and appropriate Assessment and documentation was completed. No other residents were negatively affected by this alleged deficient practice. Other residents have the potential to be affected by the alleged deficient practices. An audit was conducted to ensure		

*F514 POC accepted
10/20/16
Karen Lampson RAL*

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F 514	<p>Continued From page 9</p> <p>the June treatment sheet, the treatment was not signed off at all,, also not at all on the July or August treatment sheets, until it was discontinued by the physician in early August. The order was in place during that time period. Per interview on 9/20/16 at 2:45 PM, the Director of Nursing confirmed that this was an active order from April to August, and that staff did not document provision of this treatment as listed above.</p> <p>2. Per record review, Resident #84 was admitted on 9/14/16 from the hospital, with a recently placed Central Venous Catheter (CVC) for dialysis access. According to nursing staff, the dialysis center is managing the CVC, and they were not to do any flushes, just to monitor the site, and know the emergency procedures if there was problem with the catheter. Per the facility's policy, nursing is supposed to assess and document every shift on the catheter location, site appearance, security of clamps, and assessment of dressing. Per review of the nursing progress notes, there was no documented evidence that nursing was regularly monitoring the Central Venous Catheter site per the policy. Resident #84 stated that the facility nurses were looking at the CVC site frequently, and that they change the dressing at the dialysis center. Per interview on 9/21/16 at 10:45 AM, the Director of Nursing confirmed that there was no documentation to indicate that nursing was assessing the site every shift per facility policy.</p> <p>3. Per record review, staff failed to check Resident # 28's oxygen saturation (O2 sat) levels as ordered by the physician. There is a physician</p>	F 514	<p>Any current resident with central line Care has the protocol sheet in use.</p> <p>For resident #28 new orders for oxygen were obtained. No other resident was negatively affected. An audit was completed to review orders for Oxygen and ensure they have been assessed and documented as ordered. Nursing staff will be educated on Standards of professional assessment And documentation related to Provision of nursing care related to Treatments, central line care and Oxygen.</p> <p>CNE and or designee will conduct weekly audits x3 to ensure compliance and then monthly x3 with results to be reviewed at QAPI meeting for further review and recommendations. Date of compliance: 10/21/2016</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/21/2016
NAME OF PROVIDER OR SUPPLIER BELAIRE QUALITY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 35 BEL-AIRE DRIVE NEWPORT, VT 05855		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 10 order last signed 4/13/16 and continued on unsigned printed orders to check O2 sats every shift. Per review of the Medication Administration Record (MAR), there is no documentation that staff checked O2 sats on 53 occasions between 5/1/16 - 8/31/16. On 09/19/2016 at 4:19:12 PM, the Director of Nurses (DNS) confirmed that O2 sats are not being done as ordered by the physician. The DNS also confirmed staff should be checking and documenting O2 sats every shift as per MD order.	F 514			