

Division of Licensing and Protection  
103 South Main Street  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

March 26, 2015

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

Provider #: 475049

Dear Ms. Mayhew:

The Division of Licensing and Protection conducted an onsite complaint investigation on **February 24, 2015**. The purpose of the investigation was to determine if your facility was in compliance with Federal participation requirements of the Medicare/Medicaid Program. The investigation was completed on **February 24, 2015** and there were no regulatory violations related to the complaint allegations.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Enclosure

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>475049</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>02/24/2015</b> |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELAIRE QUALITY CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>35 BEL-AIRE DRIVE<br/>NEWPORT, VT 05855</b> |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
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|-------|---|-------|--|--|
| F 000 | <p><b>INITIAL COMMENTS</b></p> <p>The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 2/24/14. There were no regulatory violations as a result.</p> | F 000 |  |  |
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|---|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|-------|-----------|

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.