

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

September 9, 2014

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

Provider ID #: 475049

Dear Ms. Mayhew:

The Division of Licensing and Protection completed a recertification and investigation survey at your facility on **September 4, 2014**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements. Congratulations to you and your staff.

Please sign the enclosed CMS 2567 and return to this office by **September 19, 2014**.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Enclosure

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

PRINTED: 09/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/04/2014</b>
--	---	--	---

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

F 000	INITIAL COMMENTS  An unannounced onsite recertification survey and an investigation of a self-reported incident and a complaint were conducted by the Division of Licensing and Protection from 9/2/14 - 9/4/14. The facility was found to be in substantial compliance with regulatory requirements.	F 000		
-------	---	-------	--	--

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.