

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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 6, 2013

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

Provider ID #: 475049

Dear Ms. Mayhew:

The Department of Public Safety completed a Life Safety Code Survey at your facility on August 20, 2013. This survey found your facility to be in Substantial Compliance with all Fire Safety and ANSI standards.

Enclosed is the Deficiency Summary Sheet, Form CMS-2567, which requires your signature in accordance with instructions noted on the form. Please return the form to this office no later than **September 16, 2013**.

If you have any questions regarding this report, please do not hesitate to contact me.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

Enclosure



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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475049 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 08/20/2013 |
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|---|---|
| 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 |
|--------------------|--|---------------|---|----------------------|
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| K 000 | <p>INITIAL COMMENTS</p> <p>An unannounced on-site Life Safety Code inspection was completed by the Division of Fire Safety on 8/20/13. The facility was found to be in substantial compliance with applicable Life Safety Code requirements.</p> | K 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.