



VERMONT

**Department of Disabilities, Aging and
Independent Living**

Division of Licensing and Protection

280 State Drive/HC 2 South

Waterbury, VT 05671-2060

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AGENCY OF HUMAN SERVICES

June 9, 2025

Anthony Trujillo, Administrator
Bel Aire Center
35 Bel-Aire Drive
Newport, VT 05855-4953

Provider #: 475049

Dear Mr. Trujillo:

The Division of Licensing and Protection conducted an onsite complaint investigation on **May 28, 2025**. 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 **May 28, 2025**, and there were no regulatory violations related to the complaint allegations.

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

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

PRINTED: 06/09/2025
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 C 05/28/2025
NAME OF PROVIDER OR SUPPLIER BEL AIRE 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 The Division of Licensing and Protection conducted an unannounced, onsite investigation of two complaints and one FRI [facility reported incident], including reports #[23772, 24057, and 23844] on 5/28/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. There were no federal regulatory violations identified as a result.	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.