



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
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

To Report Adult Abuse: (800) 564-1612

Survey and Certification Fax (802) 241-0343

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

June 7, 2019

Jo Evans, Manager  
Lakeview Community Care Home  
322 St Paul Street  
Burlington, VT 05401-4647

Dear Ms. Evans:

The Division of Licensing and Protection completed a complaint investigation at your facility on **June 4, 2019**. The purpose of the investigation was to determine if your facility was in compliance with Residential Care Home Licensing Regulations. There were no regulatory violations as a result of this investigation.

If you have any questions regarding this report, please feel free to contact this office at (802) 241-0480.

Sincerely,

A handwritten signature in cursive script that reads "Pamela Cota RN".

Pamela Cota, RN  
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0177</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/04/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW COMMUNITY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>322 ST PAUL STREET BURLINGTON, VT 05401</b>
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(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) COMPLETE DATE
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R100	Initial Comments:  An unannounced onsite investigation of a complaint was conducted on 6/4/2019 by the Division of Licensing & Protection. There were no regulatory deficiencies identified as a result of the investigation.	R100		
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Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_