VERMONT

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
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 30, 2023

Ms. Patricia Horn, Administrator
Cedar Hill Health Care Center
49 Cedar Hill Drive
Windsor, VT 05089-9470

Dear Ms. Horn:

Enclosed is a copy of your acceptable plans of correction for the re-certification survey conducted on **April 19, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475046 | A. BUILDING _____ B. WING _____ | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDAR HILL HEALTH CARE CENTER | 49 CEDAR HILL DRIVE WINDSOR, VT 05089 |

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| E 000 | Initial Comments<br><br>The Division of Licensing and Protection conducted an investigation of the facility's Emergency Preparedness Plan was conducted during an onsite, unannounced re-certification survey from 4/18/2023 to 4/19/2023. The following regulatory deficiency was cited as a result: | E 000 | | |
| E 039 SS=C | EP Testing Requirements<br>CFR(s): 483.73(d)(2)<br><br>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. | E 039 | Cedar Hill Health Care had three actual emergency events in 2022. Our staff handled these emergencies, used them to facilitate training, evaluated our response, and wrote after action reports. Our lack of also conducting a table top or community exercise in 2022 - in addition to these - did not affect residents.<br><br>Going forward, Cedar Hill will ensure that it conducts a table-top exercise or participates in a wider community each year in addition to any actual emergency events that occur so we fully meet the CMS requirement for a second drill.<br><br>To ensure this, we will plan the mandatory exercises as part of our Emergency Planning Committee.<br><br>We will monitor this through our quality assurance program when we do our annual Emergency Plan review.<br><br>This corrective action will be completed by May 30, 2023 and ongoing.<br><br>This plan of correction will be monitored at the facility's Quality Assurance meeting for one year. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Flynn LNHA — TITLE — (X6) DATE: 5-19-2023

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.

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| E 039 | Continued From page 1<br>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, | E 039 | **Tag E 039 POC accepted on 5/25/23 by K. Ruffe/P. Cota** | |

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| E 039 | Continued From page 2<br>opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a | E 039 | | |

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| E 039 | Continued From page 3<br>narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant | E 039 | | |

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| E 039 | Continued From page 4<br>emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency | E 039 | | |

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| E 039 | Continued From page 5<br>scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.<br><br>*[For LTC Facilities at §483.73(d):]<br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. | E 039 | | |

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| E 039 | Continued From page 6<br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. | E 039 | | |

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| E 039 | Continued From page 7<br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. | E 039 | | |

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| E 039 | Continued From page 8<br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the | E 039 | | |

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| E 039 | Continued From page 9<br>facility failed to test the emergency plan twice a year by conducting a second annual exercise. Findings include:<br><br>Per review of the facility's emergency plan testing documentation, no evidence could be found that a second annual exercise to test the emergency plan had been conducted.<br><br>Per interview on 4/19/2023 at approximately 10:00 AM, the Administrator confirmed that a second annual exercise had not been conducted since the last re-certification survey. | E 039 | | |
| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an onsite, unannounced re-certification survey from 4/17/2023 through 4/19/2023. The following regulatory deficiencies were identified as a result: | F 000 | The three residents identified during survey will be given notices by 5/12/2023. | |
| F 582 SS=B | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must–<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this | F 582 | Identification of other residents with the potential to be affected: Cedar Hill has determined which residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. An audit will be completed on current residents who were admitted in the last six months, and corrective action will be completed by 5/12/2023.<br>To reduce the risk of future occurrences, the Administrator and the Director of Finance educated the following staff on the facility's Advanced Beneficiary Notices policy: Social Services Director, MDS Coordinator, Director of Nursing, Rehab Director, Clinical Coordinator, and | |

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| F 582 | Continued From page 10<br>section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to provide notice of changes in | F 582 | Assistant Administrator. We keep copies of the relevant forms in the offices of the Director of Finance and the Social Services Director. These actions will be completed by 5/26/2023.<br><br>We will monitor the corrective action by having our Assistant Administrator conduct an audit of all residents ending a Medicare A stay in the next 90 days to verify that the notices were issued timely and appropriately.<br><br>The corrective action completion date will be May 26, 2023 and ongoing.<br><br>This plan of correction will be monitored at the facility's Quality Assurance meeting for one year.<br><br>**Tag F 582 POC accepted on 5/25/23 by K. Ruffe/P. Cota** | |

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|---|---|---|---|
| | 475046 | A. BUILDING _____ B. WING _____ | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDAR HILL HEALTH CARE CENTER | 49 CEDAR HILL DRIVE WINDSOR, VT 05089 |

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| F 582 | Continued From page 11<br>coverage by Medicare for three of three sampled residents (Residents #11, #30, and #4). Findings include:<br><br>Per record review, Residents #11, #30, and #4 were provided with the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) for services that would no longer be covered by Medicare due to no longer being necessary. These 3 Residents did not receive a Notification of Medicare Non-Coverage (NOMNC). All 3 Residents remained in the facility after coverage ended.<br><br>Per interview on 4/18/23 at approximately 11:30 AM, the Director of Financial Services confirmed that Residents who remained in the facility after the coverage end date had not been receiving a NOMNC to date. | F 582 | | |
| F 623 SS=B | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section. | F 623 | The state ombudsman will receive all transfer notices for the past 6 months. This will be completed by 5/19/2023.<br><br>The facility determined that all residents transferred or discharged have the potential to be affected.<br><br>The DNS, or designee, will conduct an in-service education with all nurses and the Social Services Director, addressing the circumstances requiring transfer notices and that residents and resident representatives and the State Ombudsman receive a copy on transfer or discharge. This will be completed by 5/26/2023. | |

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| F 623 | Continued From page 12<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; | F 623 | The Clinical Coordinator, or designee, will audit the record of all residents transferred or discharged from the facility for 90 days to ensure the record includes a copy of the transfer/discharge notice and a notification that the resident, Resident Representative and the Ombudsman received a copy.<br><br>The corrective action will be completed by May 26, 2023 and ongoing.<br><br>This plan of correction will be monitored at the facility's Quality Assurance meeting for one year.<br><br>**Tag F 623 POC accepted on 5/25/23 by K. Ruffe/P. Cota** | |

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| F 623 | Continued From page 13<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by: | F 623 | | |

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| F 623 | Continued From page 14<br>Based on staff interview and record review the facility failed to provide facility transfer notices prior to transfer for residents and/or their representatives, and to send the same transfer notice (or a copy of it) to a representative of the Office of the State Long-Term Care Ombudsman for 10 out of 10 sampled residents (Residents #1, #2, #3, #7, #8, #10, #11, #13, #18 and #38).<br><br>Findings include:<br><br>Record review on 04/18/23 of a hospitalization for Resident #18 shows this resident was transferred to the Emergency Room (ER) on the date of 01/14/23 with no evidence found of a transfer notice being provided to the resident or resident representative.<br><br>Interview with the Director of Nursing (DNS) on 04/18/23 revealed that the facility has not provided transfer or discharge notices to any of their residents or to the Ombudsman "in the past year". The DNS stated this was, "an oversight maybe due to staffing changes".<br><br>On 04/19/23 An Action Summary list was provided to this surveyor showing ten ER transfers from 04/17/22 through 04/18/23. The list was comprised of all resident ER transfers in this time period. The DNS stated, "none of the residents on the list, or their representatives, or the Ombudsman had been provided with a transfer notice" at any time.<br><br>On 04/20/23 the regulatory requirements for transfer and discharge notices were discussed with the DNS, the regulation was shown to her/him, and the DNS confirmed Residents #1, #2, #3, #7, #8, #10, #11, #13, #18 and #38 were | F 623 | | |

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| F 623 | Continued From page 15<br>not provided with a transfer notice at any time, nor were their representatives or the local Long-Term Care Ombudsman. | F 623 | | |
| F 625 SS=B | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility failed to provide a written copy of a | F 625 | Cedar Hill reviews the bed hold policy at admission, includes the policy in its admission agreements, and provides another copy of the policy in the information packet that goes with the resident when he/she goes to the hospital. Our Social Service Director then calls the resident and/or the resident representative to insure they received the notice and notes the bed hold choice. In addition to those actions, Cedar Hill nurses will now review the bed hold policy with the resident and/or the resident representative during the discussion about sending the resident to the hospital and make a note of that discussion in the resident's medical chart. If the nurse cannot speak with the resident or the resident representative, the Social Services Director will call the next business day.<br>Immediate action(s) taken for the resident(s) found to have been affected: We have identified the residents affected and will audit all discharges and bed holds weekly for 90 days.<br>Identification of other residents having the potential to be affected: All residents have the potential to be affected.<br><br>Actions taken/systems put in place to reduce the risk of future occurrence include:<br>The Director of Nursing Services and the Social Services Director will train all licensed nurses on the requirement to notify resident/ resident representative of bed hold policy before transfer. This will be completed by 5/26/2023. | |

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| F 625 | Continued From page 16<br>Bed-Hold notice to residents and/or their representatives prior to transfer or discharge or in case of emergency, within 24 hours for 3 of 10 sampled residents (Residents #18, #8, and #7).<br><br>Findings include:<br><br>Record review on 04/18/23 of a hospitalization for Resident #18 shows this resident was transferred to the Emergency Room (ER) on the date of 01/14/23 with no evidence found of a written Bed-Hold notice being given to the resident or resident representative. At the time of the record review the Director of Nursing was asked if s/he could provide evidence of the required Bed-Hold Notice but s/he could not produce this.<br><br>It was noted that the Bed-Hold Notice is provided in the facility's admission packet and reviewed with residents or their representatives upon admission, however Federal regulations require facilities to issue two notices related to bed-hold policies.<br><br>On 04/19/23 An Action Summary list was provided to this surveyor showing ten ER transfers since April of 2022. Two additional resident ER transfers were performed without the required Bed-Hold Notice; the additional residents were Resident #8 who was transferred to the ER on 11/15/22, and Resident #7 who was transferred to the ER on 11/15/22.<br><br>On 04/19/23 at 12:55 PM, the Director of Nursing (DON) confirmed there was no documentation to show that the required Bed-Hold notices for Residents #18, #8, and #7 had been given to the residents and/or their representatives at the time | F 625 | Cedar Hill will monitor corrective actions to ensure the practice will not recur: The Director of Nursing Services, or designee, will audit residents who have been admitted or discharged weekly for four (4) consecutive weeks. She/he will audit to ensure proper notification of the bed hold was provided to the resident and/or legal representative and documented.<br><br>The corrective action will be complete by May 26, 2023.<br><br>This plan of correction will be monitored at Quality Assurance meetings for one year.<br><br>**Tag F 625 POC accepted on 5/25/23 by K. Ruffe/P. Cota** | |

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| F 625 | Continued From page 17<br>of the ER transfers, or within 24 hours of those transfers. | F 625 | | |
| F 732 SS=B | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the | F 732 | | |

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| F 732 | Continued From page 18<br>posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews the facility failed to update the required posted staffing information at the beginning of each shift.<br><br>Findings include:<br><br>On 4/19/23 at 9:30 am, 11:00 am and 12:18 pm, observation of the facility's staffing posting in the lobby revealed that the schedule posted was dated for 4/18/23. The posting was not updated at the beginning of each shift as required. | F 732 | At the time of this survey, Cedar Hill had the day's schedule posted in two locations. The scheduler updated the daily nurse staffing data on the day of survey at the Nurse's Station but did not in the lobby location. To prevent this from reoccurring, we are eliminating the lobby location so we only have the one schedule to update.<br><br>1. No residents were affected by this deficient practice.<br>2. The facility determined that no future residents will be affected.<br>3. We removed the staffing information from the front lobby on 5/10/2023.<br>4. The corrective actions will be monitored by the DON to ensure the staffing information is posted appropriately five days a week for one month.<br>5. The corrective action was complete on May 10, 2023.<br>6. This plan of correction will be monitored at Quality Assurance meetings for one year.<br><br>**Tag F 732 POC accepted on 5/25/23 by K. Ruffe/P. Cota** | |