

**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 <u>http://www.dail.vermont.gov</u> 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,

Jamela Mcota RN

Pamela M. Cota, RN Licensing Chief

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		475046	B. WING	Û.	04/19/2	2023
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZI	PCODE	
CEDAR H	LL HEALTH CARE CEN	TER		49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(XS) DMPLETIC DATE
E 000	Initial Comments		EC	000		
	during an onsite, una survey from 4/18/202	gation of the facility's Iness Plan was conducted Innounced re-certification				
	EP Testing Requirem CFR(s): 483.73(d)(2) §416.54(d)(2), §418. §460.84(d)(2), §482. §483.475(d)(2), §484 §485.542(d)(2), §485 §485.920(d)(2), §491 *[For ASCs at §416.5 at §485.542, OPO, "( §485.727, CMHCs at §491.12, and ESRD (2) Testing. The [facility must do all of the foll (i) Participate in a full community-based even (A) When a commun accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the eme exempt from engagin community-based or functional exercise for	113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 6625(d)(2), §485.727(d)(2), 12(d)(2), §494.62(d)(2). 64, CORFs at §485.68, REHs Drganizations" under §485.920, RHCs/FQHCs at Facilities at §494.62]: ity] must conduct exercises y plan annually. The [facility] owing: -scale exercise that is ery 2 years; or ity-based exercise is not a facility-based functional rs; or ] experiences an actual emergency that requires rgency plan, the [facility] is	EC	<ul> <li>emergency events in handled these emerge facilitate training, evaluant of the exercise in 2022 - in not affect residents.</li> <li>Going forward, Cedal it conducts a table-top participates in a wide in addition to any act that occur so we requirement for a sector.</li> <li>To ensure this, we will exercises as part of corrective action May 30, 2023 and on This plan of corrective action</li> </ul>	2022. Our staff encies, used them to luated our response, n reports. Our lack of le top or community addition to these - did r Hill will ensure that p exercise or r community each year tual emergency events fully meet the CMS cond drill. Il plan the mandatory our Emergency hrough our quality when we do our annual ew.	
BORATORY	actual event. DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 }E	TITLE	5-19-202	DATE

Any beficiency 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.

PRINTED: 05/02/2023 FORM APPROVED OMB NO. 0938-0391 .

	S FOR MEDICARE &				1	0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		475046	B. WING		04/*	9/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR HI	CEDAR HILL HEALTH CARE CENTER			9 CEDAR HILL DRIVE NINDSOR, VT 05089		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO DATE
E 039	Continued From page 1		E 039	Tag E 039 POC accepted	on 5/25/23 by	
		onal exercise at least every 2		K. Ruffe/P. Cota	_	
	years, opposite the year the full-scale or					
		nder paragraph (d)(2)(i) of				
		cted, that may include, but is				
	not limited to the follo (A) A second full-scal					
	• •	individual, facility-based				
	functional exercise; o					
	(B) A mock disaster of					
		se or workshop that is led by				
		des 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.					
		ity's] response to and ion of all drills, tabletop				
		gency events, and revise the	1			
	[facility's] emergency					
	*[For Hospices at 418					
		ces that provide care in the		E.		
		hospice must conduct				
		emergency plan at least				
		e must do the following: Il-scale exercise that is			6	
	community based ev					
		ity based exercise is not				
		an individual facility based				
	functional exercise e					
		periences a natural or				
		cy that requires activation of				
		the hospital is exempt from				
	engaging in its next r					
	community-based ex					
	onset of the emerger	nal exercise following the				
	-	ional exercise every 2 years,				
		10.10. 0.010100 0 voly 2 yours,				8

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		NSTRUCTION	(X3) DA	TE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:					MPLETED
		475046	B. WING				
	ROVIDER OR SUPPLIER	473048	B. WING	etDE	ET ADDRESS, CITY, STATE, ZIP CODE		04/19/2023
	ROVIDER OR SOFF EIER				ETADDRESS, CITT, STATE, ZIP CODE	1	
CEDAR H	ILL HEALTH CARE CEN	TER			DSOR, VT 05089		
(X4) ID	1	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC DATE
E 039	Continued From page 2		E	039			
	opposite the year the	e full-scale or functional					
	exercise under parag	raph (d)(2)(i) of this section	4				
	1	ay include, but is not limited					
	to the following:						
	(A) A second full-sca						
		a facility based functional					
	exercise; or		3	ŝ.			
	(B) A mock disaster						
		ise or workshop that is led by					
		des a group discussion using					
	a narrated, clinically-	f problem statements,					
		or prepared questions	*				
1	-	e an emergency plan.	1				
	(3) Testing for hospic	es that provide inpatient				3	
	care directly. The ho	spice must conduct					
	exercises to test the	emergency plan twice per					
	year. The hospice m						
	1	annual full-scale exercise that					
8	is community-based;						
		ity-based exercise is not					
	accessible, conduct a						
	facility-based function						-
		periences a natural or cy that requires activation of					
		the hospice is exempt from	1				
		equired full-scale community					
8		ed functional exercise	-				
1	•	f the emergency event.					
	-	ional annual exercise that					
	may include, but is n	ot limited to the following:					
	(A) A second full-sca						
	community-based or	a facility based functional					
	exercise; or						
	(B) A mock disaster						
		se or workshop led by a					
	tacilitator that include	es a group discussion using a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IFH311

Facility ID: 475046

If continuation sheet Page 3 of 19

	OF DEFICIENCIES			יוסוד		( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	<u>D. 0938-03</u>
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD				E SURVEY PLETED
		475046	B. WNG			04	/19/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAD U	ILL HEALTH CARE CEN			4	9 CEDAR HILL DRIVE		
	ILL NEALTH CARE GEN	IER		۱v	WINDSOR, VT 05089		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
E 039	Continued From page 3		E	039			
E 005				039			
	-	levant emergency scenario,					
	and a set of problem	ed questions designed to					
	challenge an emerge						
		pice's response to and					
		ion of all drills, tabletop					
	1	gency events and revise the					
	hospice's emergency	· ·					
	*[For PRFTs at §441.						
	§482.15(d), CAHs at						
		F, Hospital, CAH] must					lij
		test the emergency plan	1				
	twice per year. The [ do the following:	PRTF, Hospital, CAH] must	ALC: NO PARTY OF THE PARTY OF T				
		innual full-scale exercise that	1				
	is community-based;						
		ty-based exercise is not					
	accessible, conduct a						
	facility-based functior				-		
	(B) If the [PRTF, Hos	pital, CAH] experiences an					
	actual natural or man	-made emergency that					5
		the emergency plan, the				2	
		m engaging in its next					2
		mmunity based or individual,					
		nal exercise following the					
	onset of the emergen						
		additional] annual exercise or but is not limited to the					
	following:						
	(A) A second full-sca	le exercise that is					
		individual, a facility-based					
	functional exercise; o						
		disaster drill; or					
		ercise or workshop that is					
	led by a facilitator and	-					
		arrated, clinically-relevant					
		-	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY	
ND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED	
		475046	B. WING		0	04/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COL			
CEDAR H	ILL HEALTH CARE CEN	ITER		49 CEDAR HILL DRIVE WINDSOR, VT 05089			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATÊ	
E 039	statements, directed questions designed to plan. (iii) Analyze the maintain documentai exercises, and emerged [facility's] emergency *[For PACE at §460.4 (2) Testing. The PACE following: (2) Testing. The PACE following: (3) Participate in an a is community-based; (A) When a commun accessible, conduct a facility-based function (B) If the PACE experi- man-made emergency the emergency plan, engaging in its next r based or individual, f exercise following the event. (ii) Conduct an a years opposite the ye exercise under parage	, and a set of problem messages, or prepared to challenge an emergency [facility's] response to and tion of all drills, tabletop gency events and revise the plan, as needed. 84(d):] E organization must conduct emergency plan at least organization must do the annual full-scale exercise that or ity-based exercise is not an annual individual,	EO				
	functional exercise; c (B) A mock disaster (C) A tabletop exerc a facilitator and inclu	individual, a facility based or					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IFH311 Facility ID: 475046

If continuation sheet Page 5 of 19

				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.			COMPLETED		
		475046	B. WNG			04	19/2023	
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CEDAR HI	LL HEALTH CARE CENT	ER		WI	NDSOR, VT 05089		29	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	10	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
E 039	Continued From page	5	F	039				
2 000				0.55				
	scenario, and a set of			6				
	directed messages, or designed to challenge			5				
	(iii) Analyze the PAC							
		on of all drills, tabletop						
		ency events and revise the					1 ×	
	PACE's emergency p							
	*[For LTC Facilities at	t §483.73(d):]						
		must conduct exercises to						
	test the emergency p	lan at least twice per year,						
	including unannounce	ed staff drills using the						
	emergency procedure							
	ICF/IID] must do the f							
		nnual full-scale exercise that						
	is community-based;							
	•••	ty-based exercise is not						
	accessible, conduct a							
	facility-based function							
		facility experiences an						
		-made emergency that						
		the emergency plan, the						
		from engaging its next						
	required a full-scale of	ed functional exercise			e			
		the emergency event.						
	-	onal annual exercise that						
		of limited to the following:						
	(A) A second full-sca	-						
		an individual, facility based		2				
	functional exercise; o							
	(B) A mock disaster							
		se or workshop that is led by						
		a group discussion, using a						
		evant emergency scenario,						
	and a set of problem							
	messages, or prepare	ed questions designed to						
	challenge an emerge	ncy plan.		1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475046	B. WING			04/	19/2023
	ROVIDER OR SUPPLIER	ER		49	TREET ADDRESS, CITY, STATE, ZIP CODE CEDAR HILL DRIVE VINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	and maintain docume exercises, and emerg [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/II to test the emergency The ICF/IID must do t (i) Participate in an ar is community-based; (A) When a communit accessible, conduct a facility-based function (B) If the ICF/IID exper man-made emergency the emergency plan, t engaging in its next re community-based or i functional exercise fol emergency event. (ii) Conduct an addition may include, but is no (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster d (C) A tabletop exercise a facilitator and includuing using a narrated, clinic scenario, and a set of directed messages, on designed to challenge (iii) Analyze the ICF/II maintain documentation	facility] facility's response to ntation of all drills, tabletop ency events, and revise the emergency plan, as needed. 8.475(d)]: 1D must conduct exercises plan at least twice per year. the following: mual full-scale exercise that or ty-based exercise is not n annual individual, al exercise; or. eriences an actual natural or y that requires activation of the ICF/IID is exempt from equired full-scale ndividual, facility-based lowing the onset of the onal annual exercise that t limited to the following: e exercise that is an individual, facility-based rill; or e or workshop that is led by les a group discussion, cally-relevant emergency problem statements, r prepared questions an emergency plan. D's response to and on of all drills, tabletop ency events, and revise the	E	039			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 475046

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475046	B. WNG		n	4/19/2023
NAME OF P	ROVIDER OR SUPPLIER	Letter and the second		STREET ADDRESS, CITY, STATE, ZIP CODE		4/10/2020
CEDAR H	ILL HEALTH CARE CEN	TER		49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 039	*[For HHAs at §484.1 (d)(2) Testing. The H to test the emergency least annually. The H (i) Participate in a full community-based; or (A) When a com accessible, conduct a facility-based function or. (B) If the HHA e or man-made emerge of the emergency pla engaging in its next r community-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under parago is conducted, that limited to the followin (A) A second full community-based or functional exercise; of (B) A mock disase (C) A tabletop ex- led by a facilitator an- discussion, using a n emergency scenario, statements, directed questions designed to plan. (iii) Analyze the HHA	02] HA must conduct exercises y plan at HA must do the following: -scale exercise that is munity-based exercise is not an annual individual, nal exercise every 2 years; xperiences an actual natural ency that requires activation n, the HHA is exempt from equired full-scale individual, facility based ilowing the onset of the onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section it may include, but is not g: -scale exercise that is an individual, facility-based r ster drill; or recreise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared to challenge an emergency is response to and maintain drills, tabletop exercises, and nd revise the HHA's	E 039			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IFH311 Facility ID: 475046

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1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DNSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		475046	B. WING			04/19/2023	
	ROVIDER OR SUPPLIER	ER		49 C	EET ADDRESS, CITY, STATE, ZIP CODE EDAR HILL DRIVE IDSOR, VT 05089		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	to test the emergency following: (i) Conduct a paper-b workshop at least and led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. If the OPO exper- man-made emergency the emergency plan, f engaging in its next re- following the onset of (ii) Analyze the OPO's documentation of all t emergency events, ar OPO's] emergency plan *[ RNCHIs at §403.74 (d)(2) Testing. The RN exercises to test the e- must do the following: (i) Conduct a paper-b- least annually. A table discussion led by a fa clinically-relevant emerg- of problem statements prepared questions de emergency plan. (ii) Analyze the RNHC maintain documentati and emergency event emergency plan, as n This REQUIREMENT by:	60] PO must conduct exercises plan. The OPO must do the ased, tabletop exercise or hually. A tabletop exercise is a includes a group arrated, clinically relevant and a set of problem messages, or prepared to challenge an emergency riences an actual natural or y that requires activation of the OPO is exempt from equired testing exercise the emergency event. a response to and maintain abletop exercises, and nd revise the [RNHCI's and an, as needed. 8]: NHCI must conduct emergency plan. The RNHCI ased, tabletop exercise at top exercise is a group cilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, s, and revise the RNHCI's	E	039			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IFH311

Facility ID: 475046

If continuation sheet Page 9 of 19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		475046	B. WNG		04/19/2023
	ROVIDER OR SUPPLIER	IER		STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE	·
				WINDSOR, VT 05089	10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET
E 039	facility failed to test th year by conducting a Findings include: Per review of the faci documentation, no ev a second annual exe plan had been condu Per interview on 4/19 10:00 AM, the Admin	e emergency plan twice a second annual exercise. lity's emergency plan testing vidence could be found that rcise to test the emergency	E 03	9	
F 000	since the last re-certi INITIAL COMMENTS The Division of Licer	sing and Protection	F 00	0	
		r from 4/17/2023 through ring regulatory deficiencies		The three residents identified survey will be given notices b	5
	CFR(s): 483.10(g)(17 §483.10(g)(17) The fa (i) Inform each Medic writing, at the time of facility and when the Medicaid of- (A) The items and se nursing facility service for which the resident (B) Those other items facility offers and for charged, and the and services; and (ii) Inform each Medic changes are made to		F 58	<ul> <li>Identification of other reside potential to be affected: Cec determined which residents qualifying hospital stay and Part A benefit days availabl potential to be affected. An completed on current reside were admitted in the last six corrective action will be con 5/12/2023.</li> <li>To reduce the risk of future of the Administrator and the Di Finance educated the follow the facility's Advanced Bene Notices policy: Social Servic MDS Coordinator, Director of Rehab Director, Clinical Coordinator, Clinical Coor</li></ul>	ar Hill has with a Medicare e have the audit will be ents who months, and upleted by ccurrences, rector of ing staff on ficiary es Director, if Nursing,

-		MEDICAID SERVICES	T		OMB NO. 0938-03
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		475046	B. WING		04/19/2023
NAME OF PR	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
CEDAR HI	LL HEALTH CARE CEN	TER		9 CEDAR HILL DRIVE VINDSOR, VT 05089	
				an a	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI
F 582	resident before, or at periodically during the available in the facilit services, including ar covered under Medic facility's per diem rate (i) Where changes in and services covered Medicaid State plan, notice to residents of reasonably possible. (ii) Where changes a items and services the facility must inform the 60 days prior to imple (iii) If a resident dies transferred and does facility must refund to representative, or est deposit or charges al per diem rate, for the resided or reserved of facility, regardless of discharge notice requ (iv) The facility must the resident within 30 date of discharge from (v) The terms of an a behalf of an individual	acility must inform each the time of admission, and e resident's stay, of services y and of charges for those ny charges for services not are/ Medicaid or by the e. coverage are made to items I by Medicare and/or by the the facility must provide the change as soon as is re made to charges for other at the facility offers, the e resident in writing at least ementation of the change. or is hospitalized or is not return to the facility, the the resident, resident tate, as applicable, any ready paid, less the facility's days the resident actually or retained a bed in the any minimum stay or uirements. refund to the resident or ve any and all refunds due o days from the resident's	F 582		e and the actions tor conduct a Medicare ify that the n date will ponitored at meeting for
	by: Based on staff interv	is not met as evidenced iew and record review, the le notice of changes in			

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Facility ID: 475046

If continuation sheet Page 11 of 19

PRINTED: 05/02/2023 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		475046	B. WING		04/19/2023
	ROVIDER OR SUPPLIER	ĒR		STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089	
(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 APPROPRIA DEFICIENCY)	
F 582 F 623 SS=B	coverage by Medicare residents (Residents a include: Per record review, Re were provided with the Advanced Beneficiary services that would no Medicare due to no lo These 3 Residents due of Medicare Non-Cov Residents remained in ended. Per interview on 4/18/ AM, the Director of Fin that Residents who re the coverage end date NOMNC to date. Notice Requirements CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice M Before a facility transf resident, the facility m (i) Notify the resident representative(s) of th the reasons for the mu language and manner facility must send a co representative of the 0 Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with parage	e for three of three sampled #11, #30, and #4). Findings esidents #11, #30, and #4 e Skilled Nursing Facility v Notice (SNF ABN) for o longer be covered by inger being necessary. d not receive a Notification erage (NOMNC). All 3 in the facility after coverage /23 at approximately 11:30 nancial Services confirmed emained in the facility after e had not been receiving a Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State pudsman. is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in	F 58		e ntial to Social Istances Ints and or
FORM CMS 256	7(02-99) Previous Versions Obs	10.0 <b>3111</b> 111		2011b ID: 475046	

Event ID: IFH311

Facility ID: 475046

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PRINTED: 05/02/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
and plan of	CORRECTION	IDENTIFICATION NUMBER:	R: A. BUILDING			COMPLETED	
		475046	B. WING			04/19/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR H	ILL HEALTH CARE CENT	ER			CEDAR HILL DRIVE		
				W	/INDSOR, VT 05089		10 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 623	§483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, 1 discharge required ur made by the facility ar resident is transferred (ii) Notice must be may before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follow (i) The reason for tran (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, ar and telephone number receives such request to obtain an appeal for	of the notice. I in paragraphs (c)(4)(ii) and the notice of transfer or ider this section must be t least 30 days before the l or discharged. ade as soon as practicable tharge when- riduals in the facility would paragraph (c)(1)(i)(C) of riduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, ()(i)(B) of this section; isfer or discharge is ent's urgent medical needs, )(i)(A) of this section; or at sof the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; ich the resident is ged; a resident's appeal rights, ddress (mailing and email), ar of the entity which ts; and information on how	F	623	The Clinical Coordinator, or design audit the record of all residents tran discharged from the facility for 90 c ensure the record includes a copy of transfer/discharge notice and a not that the resident, Resident Represe and the Ombudsman received a co The corrective action will be comple May 26, 2023 and ongoing. This plan of correction will be me at the facility's Quality Assurance for one year. <b>Tag F 623 POC accepted on 5</b> K. Ruffe/P. Cota	nsferred or lays to of the ification entative opy. eted by onitored meeting	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 475046

If continuation sheet Page 13 of 19

PRINTED: 05/02/2023 FORM APPROVED OMB NO. 0938-0391

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<ul> <li>§483.15(c)(6) Changes to the notice.</li> <li>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.</li> <li>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending dosure 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). This REQUIREMENT is not met as evidenced by:</li> </ul>							
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relocation of the residents, as required at § 483.70(I). This REQUIREMENT is not met as evidenced by:							
483.70(I). This REQUIREMENT is not met as evidenced by:		•					
This REQUIREMENT is not met as evidenced by:							
by:			is not met as evidenced				
M CMS-2567(02-99) Previous Versions Obsolete Event ID: IFH311 Facility ID: 475046 If continuation sheet Page 14 of							
	RM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: IFH3	311	Facility ID: 475046	If continuation sheet	Page 14 of

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Facility ID: 475046

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE COMP	SURVEY
		475046	B. WNG		04/	19/2023
	ROVIDER OR SUPPLIER	rer	1	STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Based on staff interv facility failed to provide prior to transfer for re representatives, and notice (or a copy of it Office of the State Lo for 10 out of 10 samp #2, #3, #7, #8, #10, # Findings include: Record review on 04/ Resident #18 shows to the Emergency Ro 01/14/23 with no evid notice being provided representative. Interview with the Din 04/18/23 revealed that provided transfer or do their residents or to th year". The DNS state maybe due to staffing On 04/19/23 An Action provided to this survet transfers from 04/17/ was comprised of all time period. The DNS residents on the list, of the Ombudsman had transfer and discharg with the DNS, the regu- her/him, and the DNS	iew and record review the le facility transfer notices sidents and/or their to send the same transfer ) to a representative of the ng-Term Care Ombudsman led residents (Residents #1, #1, #13, #18 and #38). (18/23 of a hospitalization for this resident was transferred om (ER) on the date of lence found of a transfer to the resident or resident ector of Nursing (DNS) on at the facility has not lischarge notices to any of ne Ombudsman "in the past d this was, "an oversight g changes". on Summary list was eyor showing ten ER 22 through 04/18/23. The list resident ER transfers in this S stated, "none of the or their representatives, or been provided with a y time. latory requirements for e notices were discussed	F 623			

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Facility ID: 475046

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PRINTED: 05/02/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475046	B. WNG		04/19/202		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			1.	49 CEDAR HILL DRIVE			
CEDAR H	LL HEALTH CARE CEN	TER		WINDSOR, VT 05089			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 623	Continued From page	a 15	F 623				
			1 020				
	not provided with a tr	ansfer notice at any time,					
	Long-Term Care Om						
E 625		olicy Before/Upon Trnsfr	E 626	Cedar Hill reviews the bed hold p	olicy at		
			F 628	admission, includes the policy in			
39 <u>-</u> ₽	CFR(s): 483.15(d)(1)(2)			admission agreements, and prov			
	§483.15(d) Notice of	bed-hold policy and return-		copy of the policy in the informat goes with the resident when he/s	ion packet that		
	\$483,15(d)(1) Notice	before transfer. Before a		goes to the hospital. Our Social S	1		
		ers a resident to a hospital or		then calls the resident and/or the			
		therapeutic leave, the		representative to insure they reco			
		provide written information to		and notes the bed hold choice. In			
		nt representative that		those actions, Cedar Hill nurses			
	specifies-	····		the bed hold policy with the resid			
	•	e state bed-hold policy, if		resident representative during the about sending the resident to the			
		resident is permitted to		make a note of that discussion in			
	return and resume re	sidence in the nursing		medical chart. If the nurse canno			
	facility;			the resident or the resident repre			
	(ii) The reserve bed p	ayment policy in the state		Social Services Director will call	the next		
		of this chapter, if any;		business day.			
		y's policies regarding		Immediate action(s) taken for the			
		ich must be consistent with		found to have been affected: We			
		is section, permitting a		identified the residents affected a			
	resident to return; and			all discharges and bed holds weed days.	KIY TOF SU		
	· ·	pecified in paragraph (e)(1)		Identification of other residents h	aving the		
	of this section.			1	-		
	8/82 15/d//2) Dod bo	ld notice upon transfer. At		potential to be affected: All reside	ents nave the		
	the time of transfer of	•		potoniai to be aneoted.			
		apeutic leave, a nursing		Actions taken/systems put in place	ce to reduce		
		o the resident and the		the risk of future occurrence inclu			
		ve written notice which		The Director of Nursing Services			
		of the bed-hold policy	1	Social Services Director will train			
		oh (d)(1) of this section.	1	nurses on the requirement to not	•		
		is not met as evidenced		resident representative of bed ho			
	by:			before transfer. This will be comp	pleted by		
		iew and record review the	1	5/26/2023.			
	facility failed to provid						

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PRINTED: 05/02/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/19/2023	
		475046				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPL	
F 625	case of emergency, y sampled residents (F #8, and #7). Findings include: Record review on 04 Resident #18 shows to the Emergency Ro 01/14/23 with no evid Bed-Hold notice bein resident representati review the Director o could provide eviden Notice but s/he could It was noted that the in the facility's admis with residents or thei admission, however facilities to issue two policies. On 04/19/23 An Actio provided to this surve transfers since April o resident ER transfers required Bed-Hold Ni were Resident #8 wh on 11/15/22, and Res transferred to the ER On 04/19/23 at 12:55 (DON) confirmed the show that the require Residents #18, #8, a	esidents and/or their to transfer or discharge or in within 24 hours for 3 of 10 Residents #18, /18/23 of a hospitalization for this resident was transferred bom (ER) on the date of dence found of a written bog given to the resident or ve. At the time of the record f Nursing was asked if s/he ce of the required Bed-Hold I not produce this. Bed-Hold Notice is provided sion packet and reviewed r representatives upon Federal regulations require notices related to bed-hold on Summary list was eyor showing ten ER of 2022. Two additional s were performed without the otice; the additional residents to was transferred to the ER sident #7 who was	F 624	<ul> <li>Cedar Hill will monitor correct ensure the practice will not re Director of Nursing Services, audit residents who have bee discharged weekly for four (4) weeks. She/he will audit to er notification of the bed hold wa the resident and/or legal r and documented.</li> <li>The corrective action will be May 26, 2023.</li> <li>This plan of correction will be Quality Assurance meetings f</li> <li>Tag F 625 POC accepted of K. Ruffe/P. Cota</li> </ul>	cur: The or designee, will n admitted or consecutive isure proper as provided to epresentative complete by monitored at or one year.	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		475046	B. WING		04/19/2023	
	ROVIDER OR SUPPLIER	TER	4	STREET ADDRESS, CITY, STATE, ZIP CODE 19 Cedar Hill Drive Mindsor, VT 05089		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIN	
F 625	Continued From page of the ER transfers, of transfers.	e 17 r within 24 hours of those	F 625	3		
	Posted Nurse Staffing CFR(s): 483.35(g)(1)		F 732			
	<ul> <li>§483.35(g) Nurse Staffing Information.</li> <li>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:</li> <li>(i) Facility name.</li> <li>(ii) The current date.</li> <li>(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:</li> <li>(A) Registered nurses.</li> <li>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>(C) Certified nurse aides.</li> <li>(iv) Resident census.</li> </ul>					
	specified in paragrap daily basis at the beg (ii) Data must be posi (A) Clear and readab	ost the nurse staffing data h (g)(1) of this section on a inning of each shift. ted as follows: le format. ace readily accessible to				
	staffing data. The fac written request, make	for review at a cost not to				
	§483.35(g)(4) Facility requirements. The fa	data retention cility must maintain the				

Event ID: IFH311

Facility ID: 475046

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	OMB NO. 0938-03 (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		475046	B. WING		04/19/2023
NAME OF P		5 (1 <del>998/91)</del>		STREET ADDRESS, CITY, STATE, ZIP CODE	
CEDAR H	ILL HEALTH CARE CENT	ER		49 CEDAR HILL DRIVE WINDSOR, VT 05089	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVEACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET
F 732	posted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by: Based on observation failed to update the re- information at the beg Findings include: On 4/19/23 at 9:30 and observation of the face lobby revealed that the	affing data for a minimum of lired by State law, whichever is not met as evidenced as and interviews the facility equired posted staffing jinning of each shift. n, 11:00 am and 12:18 pm, ility's staffing posting in the e schedule posted was e posting was not updated	F 73	<ul> <li>At the time of this survey. Ceda had the day's schedule posted i locations. The scheduler update daily nurse staffing data on the survey at the Nurse's Station buin the lobby location. To preven from reoccurring, we are elimina lobby location so we only have schedule to update.</li> <li>No residents were affected deficient practice.</li> <li>The facility determined that future residents will be affe</li> <li>We removed the staffing information from the front lo 5/10/2023.</li> <li>The corrective actions will monitored by the DON to e the staffing information is p appropriately five days a w one month.</li> <li>The corrective action was one month.</li> <li>The corrective action was one month.</li> <li>The presence of a Quality Assurment of the staffing for one year.</li> </ul>	n two ed the day of t did not t this ating the the one by this tho cted. bbby on be nsure osted eek for complete be ance