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

July 26, 2024

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 recertification survey conducted on **June 20, 2024.** 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
Licensing Chief

Enclosure

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 _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR HILL HEALTH CARE CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 6/19/2024. There were no regulatory violations identified	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 6/17/24 through 6/19/24 with off site review on 6/20/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609	1. The resident was not affected by this. 2. Any resident has the potential to be affected by this deficient practice. All Cedar Hill employees will attend an in-service to discuss Cedar Hill's Abuse, Neglect, and Exploitation policy. 3. All Cedar Hill employees will have mandatory abuse training twice a year and on hire. 4. The monitoring of this biannual, on-hire training will be done by the Staff Development Coordinator, or designee. The results from monitoring compliance of this education will be discussed in QAPI meetings for at least 6 months. 5. This corrective action will be completed by August 5, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to report an incident of alleged abuse to the state licensing agency for 1 resident (Resident #30) of 21 sampled residents. Findings include: Per resident interview on 6/19/24 at 11:36 AM Resident #30 stated that a staff member on the overnight shift had made a fist at her/him and stated, "You can't even walk. I can knock the shit out of you." Resident #30 stated that s/he had reported this incident to a Licensed Nursing Assistant (LNA) that morning. Per record review of the facility's Abuse, Neglect, and Exploitation policy [last reviewed on 1/27/23], "Reporting of all alleged violations are brought to the charge nurse and then the nurse on call. The nurse on call notifies the director of nursing and the administrator. The Director of Nursing, administrator, or designate will notify the state agency (DAIL), Adult Protective Services [APS] ..." On 6/19/24 at 12:02 an interview was conducted with the DON [Director of Nursing] and the facility Administrator [ADM]. The DON and facility administrator confirmed that Resident #30 had reported the incident to a staff member and the	F 609	**Tag F 609 POC accepted on 7/26/24 by S. Freeman/P. Cota**	

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F 609	Continued From page 2 staff did not inform the DON and ADM. The DON confirmed the incident was not reported as required to APS or the state agency.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to revise resident care plans related to fall prevention for 1 resident [Res.#25] of 21	F 657	1. The affected resident's care plan will be revised and fall interventions added, as necessary. 2. All residents that have fallen within the last 90 days will have their fall care plans reviewed by an RN to ensure they have interventions in place for their falls. 3. All nurses will receive education about falls and care planning. This education will be added to our nurse training program. 4. The Director of Nursing, or designee, will audit all fall interventions within 48 hours of the fall. The findings from these audits will be discussed in QAPI meetings for at least 6 months. 5. This corrective action will be completed by August 5, 2024. **Tag F 657 POC accepted on 7/26/24 by S. Freeman/P. Cota**	

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F 657	Continued From page 3	F 657		

sampled residents. Findings include:

Per review of the facility's "Falls-Clinical Protocol" policy, "the staff and physician will identify pertinent interventions to try to prevent subsequent falls."
[Nursing Services Policy and Procedure Manual for Long Term Care- revised March 2018]
Review of the facility's "Nursing Floor Communication Resource" reveals under 'Falls' "Update the resident's care plan with a new intervention EVERY time a fall occurs with the resident."

An interview was conducted with the facility's Director of Nursing [DON] on 6/19/24 at 9:09 AM. The DON stated that the facility's procedure after a resident fall is to update the resident's care plan with new intervention[s] to prevent future falls.

The DON confirmed that incident reports and Nursing Notes documented Res.#25 suffering falls on 12/8/23, 12/10/23, 1/8/24, 1/10/24 and 3/24/24. The DON confirmed that Res.#25's care plan contained no new interventions to prevent future falls after falls on 12/8, 1/8, 1/10. The DON confirmed that after the falls in January with no new interventions, the resident fell again on 3/24/24. Nursing Notes dated 3/24/24 record staff "reported to this nurse that resident was lying on the floor of [h/her] room ... Did begin to complain of pain in [h/her] Left wrist. Tender to touch or move ... DON made aware and an x-ray of Left wrist will be ordered tomorrow (Monday 3/25/24)." Nursing Notes dated the next day, 3/25/24, reveal "Results of Xray returned and show acute, nondisplaced fracture of the left wrist."

Per interview and record review, the DON

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F 657	Continued From page 4 confirmed that new interventions should have been added to Res.#25's care plan after each fall to prevent future falls and injury but were not.	F 657		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726	1. No residents were found to be affected by this deficient practice. 2. No residents were found to be affected by this deficient practice. 3. Our competencies will be updated for nursing staff. These will be completed by new hires prior to ending their training period. These will be completed annually and as needed for all nursing employees. This will be performed by the Staff Development Coordinator or RN designee. 4. The tracking of on-hire and annual competencies will be performed by the Staff Development Coordinator. These findings will be reported in QAPI meetings for at least 6 months. 5. This corrective action will be completed by August 5, 2024. **Tag F 726 POC accepted on 7/26/24 by S. Freeman/P. Cota**	

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F 726	Continued From page 5 Based on interview and record review the facility failed to ensure that 1 of 4 sampled licensed nursing assistants (LNAs) and 2 of 2 sampled Licensed Practical Nurses (LPNs) were assessed for competency in the skills required to care for the resident needs based on resident care plans. Findings include: 1. Review of 1 LNA education and competency file revealed an orientation checklist that was signed off by another LNA; however, there was no evidence that the LNA was assessed for competency by a licensed nurse. 2. Review of the education and competency file for 1 LPN who was hired on 5/29/2024 revealed no evidence that they were assessed for competency in the skills needed to care for the residents. 3. Review of the education and competency file for 1 LPN who was hired on 8/23/17 revealed no evidence of annual competency evaluation of the skills needed to care for the residents. Durning interview on 6/19/2024 at 2:04 PM the Director of Nursing and the Human Resource Director confirmed that there was no evidence that the above LNAs and LPNs had been assessed for competency.	F 726		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842	1. The documentation that was removed from the charts was obtained and put back in the charts. 2. All residents were affected by this and the documentation was obtained and replaced in all residents' charts.	

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F 842	Continued From page 6 accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842	3. All Cedar Hill employees and contracted staff that have access to physical and electronic records will review and sign our HIPAA and medical record policies, and will do so annually. 4. A bright-colored sign will be added to the front of every resident's chart, reminding employees and contracted staff that medical records are not to be removed from the chart without permission of the Administrator, Assistant Administrator, or Director of Nursing. The compliance of training will be reported in QAPI meetings. 5. This corrective action will be completed by August 5, 2024. **Tag F 842 POC accepted on 7/26/24 by S. Freeman/P. Cota**	

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F 842	Continued From page 7	F 842		

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that records are complete, readily accessible, and systematically organized related to a resident's required pharmacy review for 1 out of 5 sampled residents (Resident # 3). Findings include:

Per record review, Resident # 3 was admitted to the facility on 11/13/2023. There was no evidence in the record that pharmacist conducted a monthly medical record review since admission.

During an interview with the Director of Nursing (DON) on 06/18/2024 at approximately 3:30 PM s/he stated that the facility recently changed pharmacy providers. The new pharmacist visited the facility and removed the previous pharmacy

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F 842	Continued From page 8 recommendations from paper charts and brought them home to review. The DON confirmed at the time of interview that the pharmacy recommendations were not on site or in Resident # 3's medical record. The DON stated that the pharmacist was currently on vacation and was unsure if s/he would be able to obtain the reviews. The DON was able to produce a copy of the pharmacy review form prior to the end of the survey however, s/he did confirm that the pharmacy reviews should have been in the medical record.	F 842		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that each resident had access to an effective call system at their bedside for 2 of 21 residents sampled (Resident #1 and #7). This deficient practice has the potential to affect all residents who reside in the facility. Findings include: 1. During unit observations and resident interview on 6/17/24 at 3:03 PM, Resident #1 was observed sitting in a recliner in their room trying to get assistance to go to the bathroom. Resident #1	F 919	1. Resident #1 and resident #7 have had their call bell repaired. 2. All other call bells have been inspected and repaired as needed. Our system does have the light in the hall for notifications and staff carry a handheld device. No resident call system was found to not trigger one of the devices during the facility wide inspection. A qualified technician has also inspected our system and changes have been made and are being made, per his suggestion. 3. All call bells will be inspected at least twice per week for the next two months to insure proper operation. Findings will be shared monthly at the QAPI meeting. The Committee will then decide the frequency of inspection thereafter. 4.This corrective action will be completed by August 5, 2021. **Tag F 919 POC accepted on 7/26/24 by S. Freeman/P. Cota**	

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F 919	Continued From page 9	F 919		

was asked by the Surveyor if they could ring their call bell to alert staff that s/he needed assistance. The Resident stated that s/he had been ringing and ringing and nobody was coming. The Surveyor pushed the call light button, and nothing happened. Resident #1 was pleading for help to get to the bathroom. The Surveyor went to get a Licensed Nursing Assistant (LNA) to assist. The LNA stated that s/he was not aware that Resident #1 was in need of assistance. The LNA also stated that the call lights don't work a lot of the time, and that the residents have been given hand bells to ring for help if the call light doesn't work. Upon looking for the hand bell in Resident #1's room the LNA discovered and confirmed that there was no hand bell available for Resident #1. The LNA said that s/he would get Resident #1 a hand bell and tell maintenance that the call light was not working after they assisted the resident to the bathroom.

Per interview with the Administrator and Director of Nursing on 6/17/24 at approximately 5:15 PM they were unaware of Resident #1's light not working. The Administrator stated that they do have this issue on occasion, and they provide hand bells so the Residents can summon staff.

2. During unit observations on 6/18/24 at 10:44 AM while in Resident #7's room the Surveyor pushed the call light button that was attached to the wall. The call light indicator (a box that lights up when the call button is pushed) in the hall did not light up and there was no audible signal that occurs when the call light is activated.

Per interview with the Administrator and the Assistant Administrator on 6/19/24 at 9:00 AM there are times when call lights get pulled from

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F 919	Continued From page 10 the wall a bit and need to be repositioned to work. When a call bell is not working, and staff are unable to fix it they must complete a TELS (Maintenance) request. The Assistant Administrator stated that about 10 call light checks are done weekly to ensure that they are working, and there has been a significant improvement. However, when asked if there was a system in place to check all call lights to ensure that residents could always call for assistance the Assistant Administrator and Administrator both confirmed that there was not. When asked if staff had made them aware that Resident #1's call light was not working on 6/17/24 the Assistant Administrator confirmed that the LNA had not informed anyone to fix it.	F 919		