VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

December 26, 2025

Ms. Lisa Thompson, Administrator
Cedar Hill Health Care Center
49 Cedar Hill Drive
Windsor, VT 05089

Provider ID #: 475046

Dear Ms. Thompson:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 15, 2025.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
E0000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review on 9/24/25 during the re-certification survey to determine compliance with 42 CFR Part 483.73 Emergency Preparedness requirements for Long Term Care Facilities. As a result of this review, the Facility was determined to be in substantial compliance with these requirements.	E0000	This plan of correction is In response to alleged deficiencies that are cited in the CMS-2567 from the annual survey that was conducted September 22-24, 2025.	
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of two facility reported incidents including reports #2567349 and #2567361, from 9/22/25 through 9/24/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.	F0552	The resident identified is no longer in the facility. All residents have the potential of being affected by this alleged deficient practice. An audit of all residents will be conducted. The residents on medications that require consent forms will be reviewed to ensure all residents have consent forms for the required medications. Any resident missing a consent form will have one obtained. DON or designee will conduct education with nurses on psychotropic medication administration and consent forms which will include informing in advance of the risks and benefits of the proposed care, and the treatment alternatives. An audit will occur on all residents to identify any new medication that would require a consent form to ensure that the resident or resident representative has been informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options weekly x4 and monthly x3 all findings will be brought to QAPI. **Tag F 552 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	1/22/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Chamberlain, LNHA	Administrator	12·19·25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0552 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to inform in advance of the risks and benefits of the proposed care, the treatment alternatives or other options for 1 of 5 sampled residents (Resident #3). Findings include: Per record review Resident #3 has diagnoses that include anxiety, depression, and dementia with behavioral disturbance and was experiencing increased behavioral expressions of refusing care, resistive, and combative in the evening. Resident #3 has a Durable Power of Attorney (DPOA, a person responsible for financial legal and medical decisions). A provider visit note dated 8/14/2025 states "will add some trazodone 25 [mg] bid [twice daily] as needed (PRN) to see if this helps rather than adding a standing med or change dose of sertraline Reassess in 2 weeks for prn use Discussed with DPOA [name omitted] about change in meds and [s/he] will get back [to] us." Further record review reveals that the trazodone was started however, there is no evidence of response from the DPOA related to the implementation of PRN trazodone. An alert note dated 8/21/2025 reflects that trazodone 25 mg by mouth two times a day and 25 mg by mouth as needed for agitation related to depression was ordered. There is no documented evidence in the record that the DPOA was aware of the new scheduled order or offered informed consent of the risks and benefits of this increase in trazodone. A provider visit note dated 8/27/25 states "On sertraline 50mg PO [by mouth] daily Indication: depression at this time Sertraline will be increased to 75mg PO daily per Geriatric Psych recommendations... On trazodone 25mg PO BID Indication: agitation at this time benefits outweigh the risks, and this med will be continued." A Nursing Note Narrative dated 8/27/2025 states "POA is aware of the increase in [his/her] medication and gave consent." However, this was 12 days after the implementation of the initial trazodone and 6 days after the implementation of the scheduled trazodone. A communication note written by the facility Social Worker dated 8/28/2025 states "Worker met with [Durable Power of Attorney, (DPOA)] to go over [their] questions about [the Resident's] emerging resistance to care seen as being combative physically and or verbally. [DPOA] has approved [the Resident's] change in medication of returning the Sertraline to 75mg per day and adding Trazadone 25mg BID [twice daily] for depression/anxiety to address associated behaviors. [DPOA] asked questions to be sure [the Resident] was not being sedated due to [their] behaviors. Reaffirmed that we cannot medicate as a restraint. We also reviewed [Resident's] dementia has having increased	F0552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	49 Cedar Hill Drive , Windsor, Vermont, 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
F0552 SS = D	Continued from page 2 with time since admission. Worker offered education on dementia to [DPOA] during this meeting. [DPOA] states [s/he] has been kept abreast of [Resident #3's] need for medication changes and wanted to clarify with our DON [Director of Nursing] what behaviors are emerging, what time of day, what staff is working with [the Resident] and is there enough staffing to allow [her/him] extra time to process what is asked of [her/him] i.e. ADL [activities of daily living] care needs. [DPOA] acknowledged that [s/he] still needs to get a new battery charger for [the Resident's] hearing aids which may be contributing to any potential behaviors if [the Resident] can't hear/understand what is asked of [her/him] in the moment. [DPOA] asked if [s/he] could get copies of [the Resident's] documents to better understand the changes in [the Resident] ..." A Nursing Note Narrative dated 9/11/2025 states "Resident seen by [Doctor] today for [her/his] dementia with behavior disturbances with ongoing behaviors on 3p-11p shift. Recommendations increase Trazodone to 25mg three times a day at [8:00am, 1:00pm, 5:00pm]. In 2 weeks increase Sertraline to 100mg daily in the morning. [Primary Physician] agrees with the recommendation and the orders have been entered. [Primary Physician] will call and speak with DPOA, about the changes." There is no documented evidence that the Resident's DPOA was informed of this increase in or the risks and benefits of increasing the trazodone. Per facility policy titled "Requesting, Refusing, and/or Discontinuing Care or Treatment" the Policy Statement reads "Residents and resident representatives have the right to request, refuse and/or discontinue treatment. "Treatment" refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms." The policy also states "Residents/representatives are informed (in advance) of: a. the care that will be furnished or made available to the resident based on his or her assessment or plan or care; b. the risks and benefits of the proposed care, treatment, treatment alternatives or treatment options;" During an interview with a Registered Nurse (RN) on 9/24/2025 at 1:09 PM she confirmed that there was no documented evidence that Resident #3's DPOA had consented for the initial trazadone order on 8/14/2025 and the increase on 8/21/2025. The RN stated that they only implement informed consent forms for antipsychotic medications. She confirmed that informed consent was not in the progress notes and there was no consent form.	F0552		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0580 SS = D	Continued from page 3 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5)	F0580	The resident identified is no longer at the facility. All residents have the potential of being affected by this alleged deficient practice. An audit of resident representatives will be conducted. Review of all abnormalities outside established parameters including abnormal blood glucose readings will be reviewed during daily clinical meeting to ensure notification was provided to resident representatives. DON or designee will educate nursing staff on the change of condition policy. An audit of all abnormal findings outside established parameters including blood glucose will be reviewed to ensure proper notification has been given in response to a change in condition weekly x4 and monthly x3 with findings being brought to QAPI. **Tag F 580 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	1/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0580 SS = D	Continued from page 4 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to notify the resident's representative of a change in condition relating to an episode of hyperglycemia that required physician's orders for additional medical treatment for 1 of 12 sampled residents (Resident #38). Findings include: Per record review of Resident #38's medical diagnosis, s/he has a diagnosis of type II diabetes mellitus with diabetic chronic kidney disease. A document titled "Resident Representative Notification of Incidents" dated 2/20/25, indicated that Resident #38's Representative wanted to be contacted for any incidents that occurred between the hours of 9 PM and 7 AM. Per record review of a progress note on 7/9/25, Resident #38 was noted to be nauseous, vomiting, and diaphoretic. The nurse took Resident #38's blood glucose level and the Resident's glucose level was 555 mg/dL. The nurse retook Resident #38's blood glucose level and the Resident's glucose level was 567 mg/dL. The nurse then contacted the provider and obtained an order for additional insulin but did not notify the family of the elevated blood glucose level or the new physician order due to this change in condition. Per interview with the Director of Nursing (DON) on 9/24/25 at 11:47 AM, when asked if the resident representative was notified of the change in condition and treatment, the DON confirmed that they were not notified.	F0580		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, Including: §483.10(e)(1) The right to be free from any . . . chemical restraints	F0605	The resident identified is no longer in the facility. All residents have the potential of being affected by this alleged deficient practice.	1/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0605 SS = D	Continued from page 5 Imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug	F0605	An audit of care plans for all residents with psychotropic medications will be conducted to ensure all residents have care planned implementation of person-centered, non-pharmacological approaches to manage behavioral expressions of distress. Residents identified with psychotropic medications without non-pharmacological approaches, will have them added to their care plans. DON or designee will conduct education with nursing staff on non-pharmacological approaches. An audit will be conducted on all residents with psychotropic medications to ensure implementation of person-centered, non-pharmacological approaches to manage behavioral expressions of distress monthly x3 and then quarterly and findings will be reviewed at QAPI. **Tag F 605 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hlii Drive , Windsor, Vermont, 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
F0605 SS = D	Continued from page 6 therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0605 SS = D	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a resident was not administered psychotropic medications without implementation of person-centered, non-pharmacological approaches to manage behavioral expressions of distress for one of two residents in the sample (Resident #3). Findings include: Per record review Resident #3 has diagnoses that include anxiety, depression, and dementia with behavioral disturbances. Further review of the record revealed that the Resident had been having behavioral expressions of distress when receiving care including refusals, resistive, and combativeness with care. On 6 different occasions nursing staff documented that Resident #3 was refusing and resistive to care, at times becoming combative, hitting staff and yelling out. There were no documented resident centered approaches implemented during these occasions of behavioral expressions of distress and the Resident's care plan did not address resident specific care needs. However, psychotropic medications were added and increased between 8/26/25 and 9/11/2025. A Nursing Note Narrative dated 8/11/2025 states "Resident was very upset with nighttime care this shift. [S/He] was yelling at staff, swearing and attempts made to pull out [her/his] supra pubic [catheter]. Settled after care was given." There is no documentation that supports that the Resident was offered any therapeutic intervention. A geriatric psychiatric consult dated 8/26/2025 reflects that Resident #3 has a history of dementia with behavioral disturbances and states that the Resident "continues to have days when [s/he] is combative punches and hits with care-worse on afternoon and evening shift." A recommendation was made to increase Sertraline (Antidepressant) from 50 mg to 75 mg daily. A Nursing Narrative Note dated 8/27/2025 states that Licensed Nursing Assistants (LNAs) "providing care after lunch reported that resident was calling out and swinging fists. LNAs attempted to calm [her/him], but [s/he] was resistive to care." An Alert Note dated 9/2/2025 states "Resident cursing and hitting LMN/s [Licensed Medication Nursing Assistants] doing care. Resident not easily redirected. Continues behavior doing care." A physicians visit note dated 9/9/2025 states "...for	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0605 SS = D	Continued from page 8 the past week or 2 nurses have documented some agitation, yelling, swearing, trying to bite, spit grab usually starting around 4 pm or so. No issues in the day or at night (none documented). Trazodone was added 8/14 bid [twice daily] but staff still states mid second shift [s/he] is agitated. Noted to have a large hematoma on his [right] forearm over the weekend. No known trauma." Under the Assessment/Plan section of the visit note it states, "Will schedule the trazodone for 8 am 4pm to see if this helps with agitation." Another geriatric psychiatric consult dated 9/11/2025 states that the Resident is "on the concern list for ongoing behaviors. Sertraline was increased from 50mg to 75mg 0n 8/28/25. [S/he] continues to have days when [s/he] is combative, punches and hits with care-worse on afternoon and evening shift. Yells out with Hoyer transfers." The recommendations made at this consult were to increase trazodone to 25mg three times per day and in 2 weeks increase sertraline to 100mg daily." There were no behavioral interventions recommended at either consult. Review of Resident #3's care plan revealed that Resident #3 had not been care planned for psychotropic medications, depression, anxiety, or dementia care including the identification of person-centered non-pharmacological interventions when refusing, resistive, or combative. The only intervention related to combativeness with care was implemented on 9/8/2025 that states "If resident is combative with care, give [her/him] space and reattempt." This intervention is under the focus of "Resident has a hematoma on [her/his] right forearm and a bruise on [his/her] left side" when s/he sustained injuries of unknown origin. A Nursing Narrative Note dated 9/16/2025 reveals that Resident #3 continued with refusals of care becoming resistive and combative stating "PRN [as needed] trazodone was given at [6:00 PM]. Resident had behaviors during HS [hour of sleep/bedtime] care. Screaming, swearing and combative." There was no documented evidence that staff implemented any non-pharmacological interventions, gave her/him space, or reattempted. Another Nursing Narrative note dated 9/17/2025 states, "Resident had behavior's during HS care. [S/He] did receive PRN trazadone prior to." A 9/23/2025 Nursing Note Narrative " [S/He] had behaviors during HS care. Screaming, swearing, uncooperative. Striking out at staff members. [S/He] was incontinent of BM [bowel movement]. Dressing was changed on sacrum. [S/He] did receive prn Trazadone prior to care." There is no documented evidence that staff gave her/him space and reattempted as directed in the care plan.	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0605 SS = D	Continued from page 9 Per interview with the MDS (Minimum Data Set, an assessment used to Identify resident care plan needs) Coordinator on 9/24/2025 at 2:18 PM she confirmed that care plan did not address the use of psychotropic medications or non- pharmacological interventions to meet the behavioral health needs of Resident #3. Ref. F656	F0605		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies	F0656	The resident identified is no longer in the facility. All residents have the potential of being affected by this alleged deficient practice. An audit of all residents comprehensive care plan related to anxiety. depression, dementia care, psychotropic medication use, and hearing impairment will be conducted. Any resident with these diagnosis not in their care plans will have them added. The DON or designee will educate MDS and nurse management on comprehensive care plans. An audit will be conducted on all residents with anxiety. depression, dementia care, psychotropic medication use, and hearing impairment monthly x3 then quarterly and findings to be brought to QAPI. **Tag F 656 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	1/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0656 SS = D	Continued from page 10 and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to create a comprehensive care plan related to anxiety. depression, dementia care, psychotropic medication use, and hearing impairment for one of 12 residents in the sample (Resident #3). Findings include: Per record review Resident #3 has diagnoses that include anxiety, depression, and dementia with behavior disturbance, is prescribed psychotropic medications for behavioral management, and has had multiple psychotropic medication changes to manage refusals of care, resistive, and combative behaviors. Review of Resident #3's care plan revealed that Resident #3 was not care planned for psychotropic medications, anxiety, depression, or dementia care and the care plan did not identify interventions related to the Resident's behavioral or dementia related care needs or what to do when Resident #3 was refusing, resistive, or combative. The only intervention related to combativeness with care was implemented on 9/8/2025 of "If resident is combative with care, give [her/him] space and reattempt." This intervention/approach is under the focus of "Resident has a hematoma on [her/his] right forearm and a bruise on his left side" when s/he sustained an injury of unknown origin. There is no documented evidence that this approach was used as indicated. A communication note written by the facility Social Worker dated 8/28/2025 states "Worker met with [Durable Power of Attorney, (DPOA)] to go over [their] questions about [the Resident's] emerging resistance to care seen as being combative physically and or verbally. [DPOA] has approved [the Resident's] change in medication of returning the Sertraline to 75mg per day and adding Trazadone 25mg BID [twice daily] for depression/anxiety to address associated behaviors. [DPOA] asked questions to be sure [the Resident] was not being sedated due to [their] behaviors. Reaffirmed that we cannot medicate as a restraint. We also reviewed [Resident's] dementia has having increased	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0656 SS = D	Continued from page 11 with time since admission. Worker offered education on dementia to [DPOA] during this meeting. [DPOA] states [s/he] has been kept abreast of [Resident #3's] need for medication changes and wanted to clarify with our DON [Director of Nursing] what behaviors are emerging, what time of day, what staff is working with [the Resident] and is there enough staffing to allow [her/him] extra time to process what is asked of [her/him] i.e. ADL [activities of daily living] care needs. [DPOA] acknowledged that [s/he] still needs to get a new battery charger for [the Resident's] hearing aids which may be contributing to any potential behaviors if [the Resident] can't hear/understand what is asked of [her/him] in the moment. [DPOA] asked if [s/he] could get copies of [the Resident's] documents to better understand the changes in [the Resident]. Worker guided [her/him] to [the DON] for further discussion on [the Resident's] behaviors and [her/his] request for documentation. Worker escorted [DPOA] down to meet with [DON] and discuss [their] concerns/questions." Per review the facility policy titled "Care Plans, Comprehensive Person-Centered" the "Policy Statement" reads 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. Further review of the Resident's care plan reveals that it does not address the need for hearing aids or interventions related to hearing loss that may help the Resident to understand. Per interview with the MDS (Minimum Data Set, an assessment used to identify resident care plan needs) Coordinator on 9/24/2025 at 2:18 PM she confirmed that care plan did not address the use of psychotropic medications and interventions to meet the behavioral health needs of Resident #3, including the Resident's dementia specific care needs.	F0656		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on the interview and record review, the facility	F0684	The resident identified is no longer in the facility. All residents with diabetes have the potential of being affected by this alleged deficient practice. An audit will be conducted on all residents who have diabetes. The medical director will review the facility diabetes policy to ensure proper monitoring and response are consistent with professional standards of practice.	1/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0684 SS = G	Continued from page 12 failed to monitor and respond appropriately to a hyperglycemic event for 1 of 12 residents (Resident #38), who had a known diagnosis of diabetes mellitus and chronic kidney disease. Specifically, the facility failed to monitor blood glucose levels and vital signs following a critically elevated glucose reading of 567 mg/dL and failed to reassess the resident's condition after insulin administration. These failures were inconsistent with professional standards of practice and the facility's own diabetes care policy and resulted in the resident being found deceased approximately ten hours after the event, without documented follow-up monitoring. Per review of Resident #38's medical diagnosis, Resident #38 had type 2 diabetes with diabetic chronic kidney disease, and long-term use of insulin. Per record review, Resident #38 is care planned for diabetic management and the monitoring and treatment of medications for side effects and their effectiveness dated 3/3/25. Per record review of a progress note dated 7/9/25, Resident #38 was noted to be nauseous, vomiting, and diaphoretic, "This writer was called in to see resident at about 2200 [10:00 PM]. Resident was complaining of feeling nauseous and diaphoretic. Resident reports that [s/he] had thrown up too. FSBG [Fingerstick Blood Glucose] taken. FSBG was 555. Repeat check performed. Follow up was 567. At 2202 [10:02 PM], call was placed to on call provider... It was noted that resident has not received any diabetic medication in over 48 hours. Verbal orders received for glargine insulin [long acting] 3 units now and 3 units at 9 am on 7/10/25. On call provider requested [his/her] FSBG to be checked before the 9am dose of glargine. Orders placed. Resident made aware. See MAR [Medication Administration Record] for details." The resident #38 had critical blood sugar (glucose) levels (hyperglycemia (high): above 400 mg/dL) of 567 mg/dL. Additionally, Resident #38 was presenting possible Diabetic Ketoacidosis (DKA) symptoms of nausea, vomiting, and diaphoresis, which is a medical emergency (referenced from Diabetes and Endocrinology of Dangerous Blood Sugar Levels (2023), https://sahyadrihospital.com/blog/dangerous-blood-sugar-levels-understanding-symptoms-and-management/). Review of a progress note dated 7/10/25 states "Initially the MAR was not showing insulin orders, but another nurse on day shift was able to see the orders and administrations for the diabetes medications. MAR	F0684	DON or designee will provide education to nurses on the diabetes management policy which will include monitoring, responding and documenting abnormal blood glucose levels. All diabetic residents will be reviewed who require blood glucose monitoring per physician and any abnormal blood glucose readings will be followed up with to ensure proper monitoring and response weekly x4 and Monthly x3, all findings will be brought to QAPI. **Tag F 684 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0684 SS = G	Continued from page 13 administration records shows that [Resident #38] had received [his/her] medications on 7/8 and 7/9. During the initial assessment, resident noted that [s/he] had been feeling poorly since lunch time on 7/9/25 and had mentioned it to several staff members." Resident #38's Electronic Health Record (EHR), revealed no evidence that the Resident received monitoring and further treatment after the nurse identified an elevated blood glucose level of 567 mg/dL and administered a long-acting insulin medication. The EHR shows no evidence that Resident #38 had any follow up blood glucose monitoring or monitoring of vital signs after this event. Per record review of the progress notes on 7/10/25, approximately ten hours after a hyperglycemic event went unmonitored, a physician pronounced Resident #38 as dead with the time of death at 8:32 AM. A progress note dated 7/10/25, it states "Resident resting at shift change. [S/he] was approached by [Physician], he came out stating that resident had passed (08:32). This writer found the resident was unresponsive to verbal or tactile stimuli, apneic [not breathing], unresponsive pupils, and an absence of heart sounds..." Per review of the facilities policy titled "Nurse Care of the Resident with Diabetes Mellitus" dated 2025, it states under the section titled "Glucose Monitoring" that "...Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on n the situation." Per interview with the Director of Nursing (DON) on 9/24/25 at 11:29 AM, she confirmed that the nurse told the provider that Resident #38 had not received any diabetic medications in 48 hours, when they had, and the provider ordered 3 units of glargine insulin (a long acting insulin that takes about 2 hours to work) On 7/9/25 when Resident #38 had a last known blood glucose level of 567 mg/dL. When asking the DON about standard orders pertaining to monitoring blood glucose levels, she reported they have them for all residents. When asked about why Resident #38 wasn't monitored after having an extremely elevated blood glucose level, she reported that she wasn't there and couldn't say, she confirmed that Resident #38 was not monitored. The DON stated that if she were there at the time of this event, she would have monitored Resident #38 and documented that in the EHR.	F0684		
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0744 SS = D	Continued from page 14 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to identify and provide treatment and services related to dementia for one of twelve residents in the sample (Resident #3). Findings include: Per record review Resident #3 has a diagnosis of dementia with behavioral disturbances including becoming resistive and combative with care. The facility policy titled Dementia- Clinical Protocol states "For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life." Review of Resident #3's care plan revealed that there was no care plan for dementia care, and the care plan did not identify dementia related care needs or what to do when Resident #3 was refusing, resistive, or combative. The only intervention related to combativeness with care was implemented on 9/8/2025 of "If resident is combative with care, give [her/him] space and reattempt." This intervention is under the focus of "Resident has a hematoma on [her/his] right forearm and a bruise on his left side" when s/he sustained an injury of unknown origin. Further record review reveals that on 6 different occasions nursing staff documented that Resident #3 was refusing and resistive to care, at times becoming combative, hitting staff and yelling out. There were no documented resident centered approaches implemented during these occasions of behavioral expressions of distress however, psychotropic medications were added and increased between 8/26/25 and 9/11/2025. A Nursing Note Narrative dated 8/11/2025 states "Resident was very upset with nighttime care this shift. [S/He] was yelling at staff, swearing and attempts made to pull out [her/his] supra pubic [catheter]. Settled after care was given." There are no resident-centered approaches to care documented in this progress note. A geriatric psychiatric consult dated 8/26/2025 reflects that Resident #3 has a history of dementia	F0744	The resident identified is no longer in the facility. All residents have the potential of being affected by this alleged deficient practice. An audit on all residents diagnosis will be conducted. All the residents with a diagnosis of dementia will have their care plans reviewed to ensure the identification and treatment services are included in their care plan. DON or designee will provide education on the dementia policy and how to identify and provide treatment and services related to dementia to nursing staff. An audit to all residents will be conducted monthly to identify any new diagnosis of dementia monthly x3 then quarterly and all findings to be reviewed at QAPI. **Tag F 744 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	1/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0744 SS = D	Continued from page 15 with behavioral disturbances and states that the Resident "continues to have days when [s/he] is combative punches and hits with care-worse on afternoon and evening shift." A recommendation was made to increase Sertraline (Antidepressant) from 50 mg to 75 mg daily. A Nursing Narrative Note dated 8/27/2025 states that Licensed Nursing Assistants (LNAs) "providing care after lunch reported that resident was calling out and swinging fists. LNAs attempted to calm [her/him], but [s/he] was resistive to care. Care was completed with no further complications. [S/He] is resting in bed at this time." An Alert Note dated 9/02/2025 states "Resident cursing and hitting LMN/s [Licensed Medication Nursing Assistants] doing care. Resident not easily redirected. Continues behavior doing care." A communication note written by the facility Social Worker dated 8/28/2025 states "Worker met with [Durable Power of Attorney, (DPOA)] to go over [their] questions about [the Resident's] emerging resistance to care seen as being combative physically and or verbally. [DPOA] has approved [the Resident's] change in medication of returning the Sertraline to 75mg per day and adding Trazadone 25mg BID [twice daily] for depression/anxiety to address associated behaviors. [DPOA] asked questions to be sure [the Resident] was not being sedated due to [their] behaviors. Reaffirmed that we cannot medicate as a restraint. We also reviewed [Resident's] dementia has having increased with time since admission. Worker offered education on dementia to [DPOA] during this meeting. [DPOA] states [s/he] has been kept abreast of [Resident #3's] need for medication changes and wanted to clarify with our DON [Director of Nursing] what behaviors are emerging, what time of day, what staff is working with [the Resident] and is there enough staffing to allow [her/him] extra time to process what is asked of [her/him] i.e. ADL [activities of daily living] care needs. [DPOA] acknowledged that [s/he] still needs to get a new battery charger for [the Resident's] hearing aids which may be contributing to any potential behaviors if [the Resident] can't hear/understand what is asked of [her/him] in the moment. [DPOA] asked if [s/he] could get copies of [the Resident's] documents to better understand the changes in [the Resident]. Worker guided [her/him] to [the DON] for further discussion on [the Resident's] behaviors and [her/his] request for documentation. Worker escorted [DPOA] down to meet with [DON] and discuss [their] concerns/questions." Review of Resident #3's care plan reveals that s/he does not have care planned interventions that address allowing extra time to process what is being asked of her/him and no interventions related to hearing loss or hearing aids	F0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0744 SS = D	Continued from page 16 that may improve her/his understanding. Another geriatric psychiatric consult dated 9/11/2025 states that the Resident is "on the concern list for ongoing behaviors. Sertraline was increased from 50mg to 75mg 0n 8/28/25. [S/he] continues to have days when [s/he] is combative, punches and hits with care-worse on afternoon and evening shift. Yells out with Hoyer transfers." The recommendations made at this consult were to increase trazodone to 25mg three times per day and in 2 weeks increase sertraline to 100mg daily." There were no behavioral interventions recommended at either consult. A Nursing Narrative Note dated 9/16/2025 reveals that Resident #3 continued with refusals of care becoming resistive and combative stating "PRN [as needed] trazadone was given at [6:00 PM]. Resident had behaviors during HS [hour of sleep/evening] care. Screaming, swearing and combative." There was no documented evidence that staff implemented any non-pharmacological interventions, gave her/him space, or reattempted. Another Nursing Narrative note dated 9/17/2025 states "Resident had behavior's during HS care. [S/He] did receive PRN trazadone prior to." A 9/23/2025 Nursing Note Narrative states, "[S/He] had behaviors during HS care. Screaming, swearing, uncooperative. Striking out at staff members. [S/He] was incontinent of BM [bowel movement]. Dressing was changed on sacrum. [S/He] did receive prn Trazadone prior to care." There is no documented evidence that staff gave her/him space and reattempted as directed in the care plan. Per interview with the MDS (Minimum Data Set, an assessment used to identify care plan needs) Coordinator on 9/24/2025 at 2:18 PM she confirmed that Resident #3's care plan did not identify the diagnosis of dementia, or Resident's dementia specific care needs. Ref. F-656	F0744		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals	F0761	There was no resident affected by the alleged deficient practice. All residents have the potential of being affected by this alleged deficient practice. The treatment cart was locked immediately. Education will be provided to nursing staff on facility policy on medication storage. Pharmacy consultant will perform quarterly medication storage audits and results will be brought to QAPI.	1/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0761 SS = D	Continued from page 17 in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review the facility failed to ensure resident medications were securely stored for 1 of 1 treatment carts observed. Findings include: During an observation on 9/23/25 at 12:05 PM, an unattended treatment cart was observed unlocked, and the Licensed Medication Nurse's Aide (LMNA) confirmed that medicated ointments were inside the cart. The cart was then locked.During an observation on 9/23/25 at 1:39 PM, an unattended treatment cart was found to be unlocked. Per interview with the LMNA at 1:39 PM, stated, "Thank you for letting me know," and then locked the treatment cart. The LMNA confirmed that the treatment cart contained prescribed medications for multiple residents and should always remain locked; however, it was not. Per the facility's "Administering Medications" policy [last revised 4/2019] states "...medication cart is kept closed and locked when out of sight of the medication nurse or aide."	F0761	DON or designee will check to ensure resident medications are securely stored. An audit of the treatment cart to ensure it is locked will be conducted weekly x4 and monthly x3. Findings will be reviewed in QAPI. **Tag F 761 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes:	F0801	No residents were found to be effected by this alleged deficient practice. All residents have the potential of being affected by this alleged deficient practice. The dietary manager has received their Food Manager Certification.	1/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0801 SS = F	Continued from page 18 §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an	F0801	Education will be provided to the administrator on the required qualifications for the position. An audit to ensure dietary manager is meeting qualifications will occur monthly x3. Will review findings in QAPI. **Tag F 801 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0801 SS = F	Continued from page 19 accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that the dietary manager possessed the required qualifications for the position. This deficient practice has the potential to affect all residents. Findings include: Per interview with the Dietary Manager on 9/24/2025 at 3:10 PM she had been enrolled in a Dietary Manager class but had to put it on hold due to the Dietician being away. The Dietary Manager confirmed that the Registered Dietician is not employed on a full-time basis and that she does not have the required qualifications to meet the regulatory requirements. During a phone interview on 9/24/2025 at 3:25 PM, the Facility Owner stated that due to the hardship of hiring a qualified Dietary Manager she hired the current manager with plans for her to become certified.	F0801		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services	F0849	The resident identified is no longer in the facility. All residents have the potential of being affected by this alleged deficient practice. An audit to be conducted of all hospice care plans. The hospice plans of care have been obtained and placed in hospice communication books. A hospice meeting which includes members of the IDT team is done monthly and as needed to collaborate.	1/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0849 SS = D	Continued from page 20 at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course	F0849	DON or designee will provide education to nursing staff on location of hospice communication books to ensure effective collaboration and the hospice policy. An audit of all residents on hospice will be conducted weekly to ensure collaboration and the plan of care is in place x4 and monthly x3. All findings will be reviewed at QAPI. **Tag F 849 POC accepted on 12/24/25 by G. Prefontaine/S. Stem**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0849 SS = D	Continued from page 21 of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.	F0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0849 SS = D	Continued from page 22 The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each	F0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor,Vermont, 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
F0849 SS = D	Continued from page 23 resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to maintain hospice records and coordinate care services for 1 of 1 residents in the sample (Resident #10). Findings include: Per review of the facilities policy titled "Hospice Program" dated 2025, it states that it is the "responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs." These include "…. Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care…communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day…obtaining the following information from the hospice… The most recent hospice plan of care specific to each resident….hospice election form…physician certification and recertification of the terminal illness specific to each resident… Names and contact information for hospice personnel involved in hospice care of each resident… instruction on how to access the hospice's 24 hour on-call system… Hospice medication information specific to each resident… Hospice physical and attending physician (if any) orders specific to each resident… Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility… in order to maintain the resident's highest practicable physical, mental and psychosocial well-being." Per review of the facilities hospice agreement with Resident #10's hospice provider titled "Nursing Facility Services Agreement For Respite Care" marked effective starting on 7/1/16, it states that hospice shall communicate with the facility and "At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient resident at Facility… Plan of care, Medications, and Orders. The most recent Plan of care, medication information and physician orders specific to each Hospice Patient residing at Facility… Names and contact information for Hospice	F0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Health Care Center	**49 Cedar Hill Drive , Windsor, Vermont, 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
F0849 SS = D	Continued from page 24 personnel involved in providing Hospice services... Instruction on how to access Hospice's 24-hour on-call system." Per review of Resident #10's Electronic Health Record (EHR), the Resident is on hospice services. Review of Resident #10's EHR revealed that they did not have a hospice care plan in their EHR or in the facilities paper hospice binder. Per interview with a Licensed Nurse on 9/23/25 at 1:42 PM, when asked how she knows Resident #10's hospice goals, she reported they usually follow the facility's care plan. When asked how often hospice was supposed to come in, she reported she wasn't sure. She confirmed that there was no hospice documentation other than the sign-in sheet in Resident #10's hospice binder. Per interview with the Director of Nursing (DON) on 9/23/25 at 1:27 PM, she reported they do not have access to any hospice records. Per interview with the DON on 9/23/25 at 4:04 PM, she confirmed that they did not have the hospice care plan for Resident #10 or any documents in their hospice binder other than the hospice sign in sheet. She reported she was unsure of how to access the hospice documents but does have access and confirmed that the hospice care plan should have been in the binder and wasn't.	F0849		