



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

February 11, 2026

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

Provider ID #: 475046

Dear Ms. Thompson:

On **January 27, 2026**, we conducted a revisit to the survey of **December 15, 2025**, to verify that your facility had achieved substantial compliance. Based on our revisit, we found that your facility is in substantial compliance with participation requirements found in Title 42, Code of Federal Regulations as of **January 22, 2026**.

If you have any questions concerning this letter, please contact me at (802) 241-0480.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

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 01/27/2026	
NAME OF PROVIDER OR SUPPLIER Cedar Hill Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 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 unannounced, onsite revisit survey at the facility on the date indicated in the upper right-hand corner of this form. The violation(s) previously identified have been corrected		E0000				
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite revisit survey at the facility on the date indicated in the upper right-hand corner of this form. The violation(s) previously identified have been corrected.		F0000				

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
---	-------	-----------