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

October 16, 2026

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 complaint investigation conducted on **September 28, 2026.** 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, 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 09/28/2026

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
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite investigation of 1 facility reported incident, including report 2798544 on 9/29/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiency was identified:	F0000		
F0607 SS = E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F0607	There was no resident identified in this deficient practice. All residents have the potential for being effected by this deficient practice. An audit of staff background checks will be conducted. The staff that require updated background checks will have them obtained. The policy for background checks will be updated with background checks to be completed by september of each year. Education will be provided to the HR director on annual background checks. An audit will be completed by the HR director or designee on background checks monthly x3 then yearly. All findings will be brought to QAPI. **Tag F0607 POC accepted on 10/15/26 by G. Prefontaine/S. Stem**	11/12/26

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
[signature]	Administrator	10/8/26

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 09/28/2026

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F0607 SS = E	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the facility failed to implement policies for screening employees by not completing the required criminal background checks for 3 out of 6 sampled staff. Findings include: Per review of the facility policy titled "Background Checks and Pre-Employment Screening" no date, it states that background checks will be conducted annually on all employees. Per review of employee human resource files, 3 of 6 sampled direct care staff who have worked at the facility for over a year do not have all of their annual state background checks completed. Per interview with the Interim Director of Nursing (DON) on 9/28/26 at 1:29 PM, she stated that the annual background checks for staff #2 had not been run yet by Human Resources but that she would make sure they were run for both staff #2 and staff #3. Per interview on 9/28/26 at 1:35 PM with the Scheduler who had been assisting with background checks, she stated that they typically run the background checks a month or two before they are due and complete them annually. Per interview on 9/28/26 at approximately 2:00 PM and 4:15 PM, the Administrator confirmed that they didn't have the annual background checks for all three employees.	F0607		