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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50431 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 ([NAME]), 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 staff did not inform the DON and ADM. The DON confirmed the incident was not reported as required to APS or the state agency.

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 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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 29776 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 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 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.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 40258 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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50336 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 [DATE]. 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 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.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 40258 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 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 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.