

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

November 23, 2015

Ms. Patricia Horn, Administrator  
Cedar Hill Health Care Center  
49 Cedar Hill Drive  
Windsor, VT 05089-9470

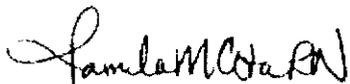
Provider ID #: 475046

Dear Ms. Horn:

The Division of Licensing and Protection completed a survey at your facility on **October 27, 2015**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements. Congratulations to you and your staff.

Please **sign the enclosed CMS 2567 and return** to this office by **December 3, 2015**.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/27/2015
NAME OF PROVIDER OR SUPPLIER  CEDAR HILL HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 49 CEDAR HILL DRIVE WINDSOR, VT 05089		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  The Division of Licensing and Protection conducted an unannounced onsite recertification survey on 10/26/15-10/27/15. The facility was found to be in substantial compliance with regulatory requirements.	F 000		

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

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.