Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 16, 2018

Ms. Amy Russell, Administrator
Mountain View Center Genesis Healthcare
9 Haywood Avenue
Rutland, VT 05701-4832

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 22, 2018**. 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
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475012	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	9 HAYWOOD AVENUE RUTLAND, VT 05701

(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
E 000	Initial Comments An unannounced on-site evaluation of the facility emergency preparedness program was conducted by the Division of Licensing and Protection between 3/19 and 3/22/18. There were no regulatory issues at this time.	E 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
F 000	INITIAL COMMENTS An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection between 3/19 and 3/22/18. There were regulatory findings surrounding the recertification survey.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain accurate MDS (Minimum Data Set) documentation for 3 of 33 sampled residents, Resident #37, #81 and #89. Findings include: 1.) Per record review on 3/20/18, the MDS dated 12/18/17 indicated that Resident #37 did not have restraints and the MDS dated 1/21/18 indicated that restraints were used less than daily. Per interview with the Licensed Practical Nurse (LPN) at 10:13 AM confirmation was made that the resident does not have restraints and the bed rails do not restrict movement and are used to assist with mobility. Per the side rail assessment completed by the facility, Resident #35 had requested the bed rail and they are used as an	F 641	F641- There was no negative impact on resident #37, #81 and #89. The MDS assessments were corrected. No other residents were affected. An audit was completed on 4/4/18 and no errors were noted at that time. Staff education regarding accurate coding of assessments was completed on 4/4/18. Will conduct weekly audits x4 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. F641 POC accepted 4/13/18 B. Bartell, RN / S. Levy, RD	4/20/18

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

CED 4/9/18

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.

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F 641	Continued From page 1 enabler in bed mobility. Per observation of the resident's bed, there were 2 upper half rails and they are non-restrictive to the resident's movement or mobility. Per interview with the MDS coordinator on 3/20/18 at 10:18 AM, s/he thought that the bed rails were restraints and confirmed at this time that the MDS was inaccurately documented. 2.) On 3/20/18, per observation, Resident #89 did not have side rails on his/her bed and per review of the medical record, there was MDS documentation dated 11/29/17 that the resident had no restraint. Further review of the medical record presented that the MDS dated 2/20/18 indicated that the resident had a restraint (side rails) that were used less than daily. Per interview with the LPN, charge nurse on 3/19/18 at 2:52 PM, the resident doesn't have a restraint and doesn't use side rails. Confirmation at 10:18 AM on 3/20/18 from the MDS coordinator that the MDS was inaccurately documented. 3. Medical record review for Resident #81 identified a Minimum Data Set (MDS) assessment dated 2/18/18 identified that the resident received an anticoagulant medication for 5 of the last 7 days. The MDS assessment is a Federal mandated assessment, used to determine the resident's health and emotional needs. Confirmation was made by the MDS Coordinator, on 3/20/18 at approximately 8:43 AM that s/he thought Plavix, was an anticoagulant. Plavix is classified as an anti-platelet medication.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657	F657- There was no negative impact on residents.#32, 73,42,101, 138, 22, 57, 117, 341, 24, 6, 15, 48, 29, 81, 133, 238, 102, 44, 112, 37, 89 and 66.	

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F 657	Continued From page 2 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of the participation of all required Interdisciplinary Team (IDT) meeting members during care plan meetings and for preparing comprehensive care plans for 23 of 33 residents. Residents #32, 73, 42, 101, 138, 22, 57, 117, 341, 24, 6, 15, 48, 29, 81, 133, 238, 102, 44, 112, 37, 89 and 66. Findings include: Record reviews conducted by the survey team during the re-certification survey between 3/19	F 657	F657: continued- Center has developed a process to better include the IDT in preparing the comprehensive plan of care. Education regarding person centered care planning was completed on 4/13/18 Audits will be conducted weekly x4 and monthly x3 to ensure IDT participation with care plan reviews. F657 - POC accepted 4/13/18 BaBartell, RN/S. Perry RN	4/20/18

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F 657	Continued From page 3 and 3/22/18 failed to produce evidence that the IDT included all required members of the team, as required per Centers for Medicare Services (CMS), to participate in the comprehensive care plans of the above identified residents. Interview with the Director of Nursing and Social Services on 3/22/18, confirmed that there is no evidence that Licensed Nursing Assistants, who are responsible for the specific resident are part of the IDT. It was further stated that a member of food and nutrition service staff is not part of the comprehensive care plan unless there is a nutritional concern.	F 657		4/20/18
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to assure that foods were served at a safe, appetizing and palatable temperature. Findings include: Per interview in the resident Council special meeting on 3/20/18 at 1 PM, Residents in attendance stated that food served in resident rooms is "always cold", especially the eggs in the morning. The majority of the 9 residents attending were from Dogwood Orive but there were other	F 804	F804- There was no negative impact on the residents. Meals are temped at time of service to ensure palatable temperatures. Staff education regarding proper temperature of food and drink at time of service was completed on 4/13/18. Will conduct weekly audits x4 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. F804 POC accepted 4/13/18 B. Barhill, RN / S. Perry, RN	

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F 804	Continued From page 4 residents from other units as well. The residents stated that the eggs were always cold and that other meals were not hot either. This surveyor raised the question because a review of the Resident Council minutes for the past 3 months showed complaints of cold food. During lunch on 3/21/18 two surveyors, on Dogwood Drive, sampled test trays and also checked the temperatures of the foods. The following observations were made: Liver & Onions and Chicken were found to be at 100 degrees, Mashed Potatoes were at 106 degrees, Scalloped Potatoes were at 105 degrees, California Mixed Vegetables were at 100 degrees on one tray and 97 degrees on the second tray, and coffee was at 160 degrees. The chocolate milk was at 60 degrees and the ice cream was soft but not melted. According to the Dietary Manager, in an interview, the food has temperature readings checked once when the food arrives on the unit. Food is delivered to the unit in pans on Dogwood Drive. The US Food and Drug Administration states, "Be aware that some warmers only hold food at 110 °F (Fahrenheit) to 120 °F, so check the product label to make sure your warmer has the capability to hold foods at 140 °F or warmer. This is the temperature that is required to keep bacteria at bay. Foods to be served cold must be held and served at temperatures of 40 degrees F or less to prevent bacteria growth."	F 804		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880	F880- There was no negative impact on residents. The nebulizer mouthpieces, C-Pap were properly stored in a bag labeled with the residents name and date on 3/21/18.	4/20/18

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F 880	Continued From page 5 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880	F880 continued: Other residents who currently have nebulizer treatments ordered were inspected relating to placement and storage of the nebulizer mouthpieces. Staff education regarding storage of said equipment was completed on 4/13/18 Will conduct weekly audits x4 to ensure compliance and then monthly x3 with results to be reviewed at QA meeting for further review and recommendations. F 880 POC accepted 4/13/18 B. Barhill, RN / S. Levy, RN	4/20/18

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F 880	Continued From page 6 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections on 1 of 4 nursing units. The findings include the following: Per initial tour on 3/19/18, the surveyor identified oxygen masks, nebulizer masks (with connected medication chambers) and a C-Pap mask not in use by the residents and resting at the bedside without protective coverings. During a Unit tour with the infection control Registered Nurse on 3/21/18 at 2:30 PM,	F 880		

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F 880	Continued From page 7 confirmation was made that three resident rooms on Beech Tree unit were observed as follows: An oxygen mask with attached medication chamber, connected to a portable oxygen tank in a carrier next to the resident's bed was unprotected; a nebulizer mask with the medication chamber attached to the nebulizer machine was unprotected at the bedside; and an oxygen cannula resting on the oxygen concentrator were unprotected. Per facility policy titled "Nebulizer" dated 1/1/04, page #2 identifies, "Upon completion of the treatment, rinse the mouthpiece and "T" piece with tap water and dry. Place in a treatment bag labeled with the patient name and date". Previously cited on 2/16/17.	F 880		

Genesis

Mountain View Center
9 Haywood Avenue
Rutland, Vermont 05701
Phone: 802-775-0007
Fax: 802-775-3241

April 9, 2018

Pamela Cota, Licensing Chief
Division of Licensing and Protection
HC 2 South
280 State Drive
Waterbury, Vermont 05671

Dear Ms. Cota:

Enclosed is the revised plan of correction for the deficiencies sited during the annual survey on March 22, 2018 for Mountain View Center. This plan of correction is our creditable allegation of compliance. Should you have any questions please call me during normal business hours.

Sincerely,

A. CED

Amy Russell, Center Executive Director

VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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April 3, 2018

Ms. Amy Russell, Administrator
Mountain View Center Genesis Healthcare
9 Haywood Avenue
Rutland, VT 05701-4832

Provider ID #: 475012

Dear Ms. Russell:

The Division of Licensing and Protection completed a survey at your facility on **March 22, 2018.** 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 and Medicaid programs. This survey found the most serious deficiency in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy as evidenced by the attached CMS-2567 whereby corrections are required. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)
A POC for the deficiencies, which is your allegation of compliance, must be received by **April 15, 2018.** Failure to submit an acceptable POC by **April 15, 2018** may result in imposition of remedies or termination of your provider certification. Your POC must contain the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- The dates corrective action will be completed.

The remedies, which will be imposed if substantial compliance has not been achieved by **April 21, 2018**, will include the following:

Denial of Payment for New Admissions effective **June 22, 2018**

An Enforcement Cycle has been initiated based on the citation of deficiencies at a "D" level or greater at your facility. All statutory/mandatory enforcement remedies are effective based on the beginning survey of the Enforcement Cycle. Your Enforcement Cycle began with the **March 22, 2018,** survey. All surveys conducted after **March 22, 2018,** with deficiencies at a "D" level or greater become a part of this Enforcement Cycle. The enforcement cycle will not end until substantial compliance is achieved for all deficiencies from all surveys within an enforcement cycle. Facilities are expected to achieve and maintain continuous substantial compliance. If you do not achieve substantial compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. We are also recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreements be terminated on **September 22, 2018** if substantial compliance is not achieved by that time. A change in the seriousness of the deficiencies on **April 21, 2018** may result in a change in the remedy selected.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may contact Suzanne Leavitt, RN, MS, Assistant Division Director, Division of Licensing and Protection with your written credible allegation of compliance. If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, the recommended remedy listed above would not be imposed at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, a civil money penalty may be imposed by the CMS Regional Office beginning on the last day of survey and continue until substantial compliance is achieved. Additionally, the CMS Regional Office will impose the other remedies indicated above or revised remedies, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to Suzanne Leavitt, RN, MSN, Assistant Division Director, Division of Licensing and Protection. **This written request must be received by this office by April 13, 2018**. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Opportunity for Independent Informal Dispute Resolution (IIDR)

If you have already requested an Informal Dispute Resolution (IDR) from the State Agency, your request for IIDR will only be allowed if it is made before the State's IDR is completed. If you chose to request an IIDR with an Independent Panel, your written request for an IIDR must be sent to Suzanne Leavitt, RN, MS, State Survey Agency Director. The State Survey Agency will forward your request to the IIDR Panel, and they will inform you when and how the IIDR will be conducted. Your request for IIDR must be made no later than **10 calendar days** from the date of your receipt of this letter.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enclosure: