

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

March 28, 2019

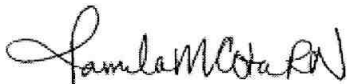
Ms. Amy Russell, Administrator  
Mountain View Center Genesis Healthcare  
9 Haywood Avenue  
Rutland, VT 05701-4832

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 11, 2019**. 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

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

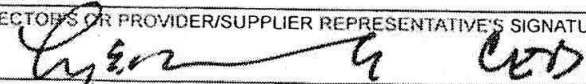
PRINTED: 03/19/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/11/2019</b>
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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	F 000		
	An unannounced on site investigation for two entity reported incidents, was conducted by the Division of Licensing and Protection on 3/11/2019. There were State Regulatory findings with one of the investigations.			
F9999	FINAL OBSERVATIONS	F9999	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.	
	2.9 Reports to the Licensing Agency			
	The following reports must be filed with the licensing agency:			
	a. At any time a fire occurs in the facility, regardless of the size or damage, the licensing agency and the Department of Labor and Industry must be notified by the next business day. A written report must be submitted to both departments by the next business day. A copy of the report shall be kept on file in the facility.		F9999- There was no negative impact on resident #1.	03/29/19
	b. Any untimely death that occurs as a result of an untoward event, such as an accident that results in hospitalization, equipment failure, use of restraint, etc., shall be reported to the licensing agency by the next business day, followed by a written report that details and summarizes the event.		The report was made to the state on 12/13/18. No other residents were affected.	
	c. Any unexplained or unaccounted for absence of a resident for a period of more than 30 minutes shall be reported promptly to the licensing agency. A written report must be submitted by the close of the next business day.		Staff education was completed on 3/26/19.	
	d. Any breakdown or cessation to the facility's physical plant that has a potential for harm to the residents, such as a loss of water, power, heat or		Audits will be conducted on a weekly basis x4 and monthly x3 with results to be reviewed at QA meeting for further review and recommendations.	
			F9999 POC accepted 3/27/19 BBortell RN/PRM	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>CEO</b>	(X6) DATE <b>3/26/19</b>
--------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------	-----------------------------

any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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.

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

PRINTED: 03/19/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/11/2019	
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER GENESIS HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
F9999	<p>Continued From page 1</p> <p>telephone communications, etc., for four hours or more, shall be reported within 24 hours to the licensing agency.</p> <p>The requirement is NOT MET as evidenced by.</p> <p>Based on staff interview and record review, the facility failed to report to the State Agent, the untimely death of 1 resident in the applicable sample, Resident #1. Findings include:</p> <p>Resident #1 had been independent with transfers and ambulation and was active at the facility until s/he had a fall at the facility on 11/22/18 at approximately 2:30 AM. After being assessed the resident was found to be in substantial pain and s/he was transferred to the hospital for evaluation and treatment. While at the hospital, x-rays presented that the resident had sustained a right hip fracture and the hospital physician felt that the long term prognosis was incredibly poor after sustaining a hip fracture that will not be repaired. After a discussion between the physician and the daughter the decision was made to have her return to the facility on comfort measures only. The resident returned to the facility 11/23/18 and declined rapidly over the week following the return to the facility and was admitted to Hospice Services on 11/27/18 and s/he died 11/30/18. Per interview with the administrator on 3/12/19 at 11:00 AM, s/he stated that the facility did not report the death until 12/13 when the death certificate became available.</p>	F9999		