VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

October 2, 2023

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

Dear Ms. Isabelle:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **September 18, 2023.** 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

| 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 _____ | C 09/18/2023 |

| 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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an unannounced complaint investigation of reports #22006 and #22222 from 9/18/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey. | F 000 | The filing of this plan of correction does not constitute an admission of allegations set forth in the statement of deficiencies. The plan of correction is prepared and executred as evidence of the facility's continues compliance with applicable law. | |
| F 582 SS=B | Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide | F 582 | F-578 - There was no negative impact on resident #1.<br><br>The refund was issued to the son of resident #1 on 9/18/2023.<br><br>An audit was completed to confirm there was no other outstanding refunds past the regulartory 30 days post discharge.<br><br>The Buisness Office Manager will complete audits weekly x4 and monthly x3 to ensure that all refunds are processed and sent out within the regulartory time period.<br><br>For future refunds, we will do audits every two weeks to ensure all refunds continue to be processed timely.<br><br>**Tag F 582 POC accepted on 10/2/23 by K. Ruffe/P. Cota** | 10/6/2023 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrater — (X6) DATE: 9/29/23

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.

| 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 _____ | C 09/18/2023 |

| 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 |
|---|---|---|---|---|
| F 582 | Continued From page 1 | F 582 | | |

notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that each resident is refunded charges already paid for days the resident did not reside in the facility within 30 days of discharge for Resident #1. Findings include:

Per record review, Resident #1 was discharged from the facility on 3/15/23. An outstanding account activity report provided for Resident #1 shows that a refund for $6,970.00 was submitted by the facility's business office manager on 4/11/23. However the current balance of the account on 9/18/23 was still -$6,790.00. A note was entered into the account on 7/27/23 that

| 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 _____ | C 09/18/2023 |

| 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 |
|---|---|---|---|---|
| F 582 | Continued From page 2<br>states "Per [facility corporate business office employee], no refund to be done until [insurance provider] has paid."<br><br>Per interview on 9/18/23 at approximately 10:00 AM, the Administrator confirmed that one of Resident #1's secondary insurance providers had not paid the facility for covered services rendered to Resident #1 after their Medicare part A benefits had been exhausted. The insurance provider claims that Resident #1's services were not skilled services and therefore not eligible for coverage, though the facility claims that it was skilled care. The Administrator also confirmed that Resident #1 and their representatives had paid for the month of March up front, but that the facility does not require this of residents. Certain managed care providers end up denying payment, or take a very long time to submit payment for services, so the facility will ask residents or families with these managed care providers if they would like to pay for the month up front and get reimbursed for any services covered later.<br><br>Per interview on 9/18/23 at approximately 11:30 AM, a Corporate Business Office employee confirmed that the managed care provider initially submitted payment for services but then took the payment back, claiming that Resident #1 was not receiving skilled services at the time and requested more documentation from the facility. Their boss instructed the facility not to issue reimbursement until the managed care provider submitted payment. The employee also stated that it was the facility's responsibility to follow up with the managed care provider to ensure that they had all the documentation they needed to confirm Resident #1 was receiving skilled | F 582 | | |

| 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 _____ | C 09/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNTAIN VIEW CENTER GENESIS HEALTHCARE | 9 HAYWOOD AVENUE RUTLAND, VT 06701 |

| (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 582 | Continued From page 3<br>services.<br><br>Per interview on 9/18/23 at approximately 11:45 AM, the facility BOM (Business Office Manager) stated that they were instructed by the Corporate Office not to initiate the reimbursement until the managed care provider payment came through. The BOM stated that they spoke with Resident #1's representative to confirm that it was ok to wait for payment to come through before issuing the refund, but the BOM has no record of this conversation. The BOM also stated that, while they submitted all the requested documentation to the managed care provider, it was their understanding that it was the Corporate Office who would be following up to ensure the payment status of the managed care provider.<br><br>Per interview on 9/18/23 at approximately 12:00 PM, the facility confirmed that the process for issuing reimbursements to Residents with outstanding balances is unclear and allowed Resident #1 to not receive their reimbursement within the regulatory timeframe of 30 days. | F 582 | | |