

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

December 4, 2014

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

Dear Ms. Morton:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 5, 2014**. 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

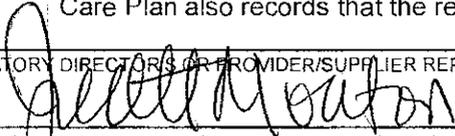
PRINTED: 11/20/2014  
FORM APPROVED  
OMB NO. 0938-0391

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  11/05/2014
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 9 HAYWOOD AVENUE RUTLAND, VT 05701
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(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  F 241 SS=E	<p>INITIAL COMMENTS</p> <p>An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 11/3-11/5/14. The following regulatory deficiencies were identified:</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to promote care for 5 of 22 residents [#45, 118, 28, 22, &amp; 160] in the sample group in a manner and in an environment that maintains or enhances each resident's dignity, self-esteem and self-worth. Findings include:</p> <p>1). Per record review Resident #45, Minimum Data Sheet [MDS], dated 9/2/14, assesses the resident as needing extensive assist with toileting with two or more persons physically assisting, and 'only able to stabilize with human assistance' when moving on and off the toilet. Resident #45 has diagnoses that include stroke, weakness or paralysis to one side of the body, anxiety and depression. Per record review Resident #45 has Care Plan documents that indicate the resident "demonstrates a deficit in toileting related to functional deterioration" with the intervention to "provide patient with needed assistance". The Care Plan also records that the resident "is</p>	F 000  F 241	<p>Mountain View Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>Resident #45, 118 and 22 will have voiding diary completed and care plans reviewed and revised. Resident #28 preferences for daily routines reviewed and care plan updated. Resident # 160 continues to work with ST and OT to achieve optimal function with eating.</p> <p>All residents have the potential to be affected by this alleged deficient practice. Nurse Manager or designee will Continue to monitor incontinence And patient preference for care needs to ensure residents are satisfied with delivery of care.</p>	12-12-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11-25-14
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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 241 Continued From page 1  
incontinent of urine with potential for improved control" and to "monitor for and assist toileting needs" and "provide access to the bathroom". Per interview with Resident #45 on 11/5/14 at 9:36 A.M., the resident stated, "they don't have staff enough to take care of us. I have waited a half hour to go to the bathroom. I take Lasix [a diuretic medication] and I have to go quite often. I've had to wait so long I couldn't wait any longer. I'll be wet. It makes me feel awful; like I've gone back to babyhood."

2). Per record review, Resident #118's Minimum Data Sheet [MDS] dated 10/20/14, assesses the resident as occasionally incontinent and needing extensive assist with toileting, 'only able to stabilize with human assistance' when moving on and off the toilet. Resident #118's diagnoses include heart failure, hypertension, stroke, and weakness or paralysis to one side of the body. Per interview with Resident #118 on 11/3/14 and 11/5/14, the resident replied 'no' when asked if h/she was treated with respect and dignity. The resident stated h/she needs assistance going to the bathroom and uses the call bell to ask for help, and "sometimes I have to wait so long I wet myself. When you have to go-you have to go. I don't feel good about it". Per record review, Resident #18 has Care Plan documents that indicate, "I [Res. #1] have had a stroke. I need assistance with bathing, grooming, dressing, moving in my bed, transfers, and toileting", with the goals including "please help me maintain what I am able to do".

3). Per record review, Resident #28's Minimum Data Sheet [MDS] dated 9/2/14, assesses the resident as needing extensive assist with

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Nurse Manager or designee to monitor dining room on this neighborhood to ensure residents receive meals in timely manner.

Nursing staff will be educated on providing care for residents while maintaining dignity and respect.

Resident council meeting to be conducted for residents residing on this neighborhood, Weekly for 4 weeks, and then monthly for 3 months.

Results of the council meetings will be discussed at CQI for further evaluation and recommendations.

Corrective action will be completed by: 12/12/14

*F241 POC accepted 12/4/14 B Borkilaw / PML*

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dressing and personal hygiene. Resident #28's diagnoses include coronary artery disease, hypertension, peripheral vascular disease, diabetes, arthritis, osteoporosis, stroke, anxiety, and depression. Per interview on 11/5/14 at 10:12 A.M., Resident #28 reported, and was confirmed per observation during the interview, that h/she was still in their night shirt and the night shirt had spilled food on it. The resident stated, "I've been up since 6:00 A.M. and its 10:15 A.M. (4 hours later) and I'm not even dressed yet. I'm lying here dirty".

4). Per record review, Resident #22's Minimum Data Sheet [MDS] dated 10/26/14, assesses the resident as needing extensive assist with toileting, and reports a condition or chronic disease that may result in a life expectancy of less than 6 months. Resident #22 has diagnoses that include heart failure, hypertension, peripheral vascular disease, diabetes, stroke, weakness or paralysis to one side of the body, anxiety, depression, and chronic obstructive pulmonary disease. Per record review, Resident #22 has a Care Plan that identifies the resident as exhibiting "occasional episodes of incontinence of urine with potential for improved control or management", with interventions that include, "respond promptly to the resident's request to use toilet." Per interview on 11/5/14 at 10:04 A.M. Resident #22 reported, "When you are sick and need some help, it takes forever [for the call bell to be answered]. I ring when I need to go to the bathroom, because when you need to go you need to go, and sometimes I can't wait any longer. It's an awful feeling".

5). Per observation on 11/3/14 Resident #160, whose diagnoses include dementia, depression,

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F 241 Continued From page 3  
and a stroke with right sided paralysis from 10/30/14, was transferred to the dining room on Dogwood unit by an Licensed Nursing Assistant [LNA] in a specialized wheel chair with right arm support at approximately 12:00 P.M. and positioned against the far wall with a portable table in front of him/her, and facing in toward the other residents in the dining area. Resident #160 was then joined by a visiting friend who sat in a chair next to the resident. Resident #160 was 1 of 13 residents in the dining room at that time, with all 13 residents awaiting their meal. At 12:19 P.M. the first meal was served to a resident at the dining room table. Per observation at 12:35 P.M., the 12 residents other than Resident #160 had all been served their meals. At 1:05 P.M., an hour after Resident #160 was brought to the dining room, the resident's friend left his/her chair and notified an LNA that Resident #160 had yet to be given any food or drink. Per interview with Resident #160's friend at 1:19 P.M., the LNA reported they were waiting for the resident's meal and waiting to feed him/her. The LNA then delivered the meal on a plate covered in plastic wrap. The LNA stated that the resident had not been brought any food or drink because they saw the friend was visiting with the resident. Per observation the LNA left and returned with a drink and apologized, stating h/she would have fed the resident but no one had told him/her. After removing the plastic wrap the resident's friend then informed the LNA that the meal was cold and asked for it to be reheated. The LNA left with the plate, returned and placed the reheated plate on the table in front of the resident and left again at 1:12 P.M. As of this time, of the 12 other residents in the dining room, 9 had finished their meal and 6 had left the dining area. Per observation and interview at

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1:19 P.M. the resident's friend had begun to feed Resident #160. Per interview when asked if any staff had offered to feed the resident, or requested that the friend feed the resident, the friend replied, "no".

Per interview with the Unit Manager [UM] and the Charge Nurse of the unit on 11/3/14 at 3:30 P.M., the UM and Charge Nurse reported that the unit's LNA's serve the residents their meals. The LNAs are to assist the residents if they see the resident is not eating and/or if it is in the resident's care plan that they need feeding assist. The UM and the Charge Nurse confirmed that greater than 1 hour was an excessive amount of time for Resident #160 to wait for a meal and/or drink, and to wait for assistance while witnessing other residents receive and finish their meals. The UM and the Charge Nurse also confirmed Resident #160 required assistance with feeding, and when the meal did arrive that assistance was not provided. Per record review of the Care Plan for Resident #160, dated the day of the observation, 11/3/14, it indicates that Resident # 160 "exhibits or is at risk for impaired swallowing related to CVA [a stroke]". Interventions include, "provide assistance during meals" and "provide direct supervision during meals."

Per Nursing Standard of Practice Protocol: Assessment and Management of Mealtime Difficulties\*: Guiding Principles include ' Persons dependent in eating will be assisted with dignity', 'Mealtime is not only an opportunity to ingest nutrients but also to maintain physical and emotional health ', and ' The quality of mealtime is an indicator of quality of life and care of an individual '.

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[[http://consultgerirn.org/topics/mealtime\\_difficulties/want\\_to\\_know\\_more](http://consultgerirn.org/topics/mealtime_difficulties/want_to_know_more)]  
F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
SS=D

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:  
Based observation, record review and staff interview the facility failed to update the interdisciplinary care plan for 1 of 3 applicable residents in the stage 2 sample of 22, Resident #64. Findings include the following:

Per medical Record review on 11/5/14 at approximately 10 AM, Resident #64 was initially admitted on 1/24/12 and readmitted on 6/16/14

F 241  
  
F 280

The care plan for Resident #64 has been reviewed and updated to address current incontinence status.

A voiding diary was completed for resident #64.

Residents who are incontinent have the potential to be affected by this alleged deficient practice.

A review will be conducted to identify residents who's MDS has changed to ensure the care plan has been updated.

Nurses will be re-educated on the required documentation and monitoring of incontinence.

DNS or designee will ensure that audits will be done weekly X 4 weeks and then monthly x 3 to ensure that the center is compliant with ensuring that a care plan has been updated.

Results of the audit will be discussed at CQI for further evaluation and Recommendations.

*F280 PDC accepted 12/4/14 B Borkil R/W/MLC*

*12.12.14*

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F 280 Continued From page 6  
with diagnosis to include Pathological Fracture of the Arm/Shoulder, Chronic Pain Syndrome, Peripheral Neuropathy, Dementia with Behavioral Disturbances, Depression/Anxiety, Anemia and Glaucoma.

Minimum Data Set (MDS) assessment dated 6/23/14 evidences that Resident #64 is always continent. MDS assessment dated 8/31/14, evidences that Resident #64 is occasionally incontinent, which is defined as less than 7 episodes of incontinence during the 7 day look back period. MDS assessment dated 9/30/14, evidences that Resident #64 is frequently incontinent, which is defined as 7 or more episodes of urinary incontinence, but at least one episode of continent voiding, over the 7 day look back period. Assessment also identifies that the Basic Interview for Metal Status (BIMS) score determines the resident to have a score of 9, signifying mild cognitive loss. The MDS assessment was confirmed by the MDS RN Coordinator on 11/5/14 at approximately 12 noon.

Per Interdisciplinary Care Plan initiated on 6/25/12 and reviewed on 10/7/14, identifies a focus/problem for Resident #64, as being occasionally incontinent of urine. Goal documents that Resident #64 will demonstrate improved urinary elimination control as evidenced by experiencing decreased urinary incontinence. Interventions are to encourage resident to use toilet upon awakening, after meals, nightly and as needed.

Per Activities of Daily Living (ADL) Record during the look back period, Resident #64 required extensive assistance of 1 or 2 staff members for toileting/transfer. Therefor, resident was

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F 280 Continued From page 7  
dependent on staff to complete the toileting task and maintain continence.

Per interview on 11/5/14 at 12:10 PM with the Director of Nurses (DNS) and the Unit Manager (UM), both confirm that Resident #64 's voiding pattern has not been thoroughly evaluated, nor has the type of incontinence the resident is experiencing been determined. The care plan has not been updated to reflect the change in urinary incontinence for Resident #64, as identified on the MDS assessment dated 9/30/14, nor has the resident received appropriate treatment to restore as much normal bladder function as possible.

F 280

F 315 SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

See also F315.

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

F 315

A voiding diary was completed for resident #64.

All residents have the potential to be affected by this alleged deficient practice.

Nursing to review residents who have had a decline in urinary incontinence to review for appropriate B&B retraining program. Resident with a potential for improvement will be placed on a toileting plan and the care plan updated.

12/2/14

This REQUIREMENT is not met as evidenced by:  
Based on observation, record review and staff interview, the facility failed to ensure that a resident who is incontinent of bladder received the appropriate treatment to restore as much

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F 315	<p>Continued From page 8</p> <p>normal bladder function as possible for 1 of 3 applicable residents in the stage 2 sample of 22, Resident #64. Findings include the following:</p> <p>Per medical Record review on 11/5/14 at approximately 10 AM, Resident #64 was initially admitted on 1/24/12 and readmitted on 6/16/14 with diagnosis to include Pathological Fracture of the Arm/Shoulder, Chronic Pain Syndrome, Peripheral Neuropathy, Dementia with Behavioral Disturbances, Depression/Anxiety, Anemia and Glaucoma.</p> <p>Minimum Data Set (MDS) assessment dated 6/23/14 evidences that Resident #64 is always continent. MDS assessment dated 8/31/14, evidences that Resident #64 is occasionally incontinent, which is defined as less than 7 episodes of incontinence during the 7 day look back period. MDS assessment dated 9/30/14, evidences that Resident #64 is frequently incontinent, which is defined as 7 or more episodes of urinary incontinence, but at least one episode of continent voiding, over the 7 day look back period. Assessment also identifies that the Basic Interview for Metal Status (BIMS) score determines the resident to have a score of 9, signifying mild cognitive loss. The MDS assessment was confirmed by the MDS RN Coordinator on 11/5/14 at approximately 12 noon.</p> <p>Per Interdisciplinary Care Plan initiated on 6/25/12 and reviewed on 10/7/14, identifies a focus/problem for Resident #64, as being occasionally incontinent of urine. Goal documents that Resident #64 will demonstrate improved urinary elimination control as evidenced by experiencing decreased urinary incontinence. Interventions are to encourage resident to use</p>	F 315	<p>Nursing staff education to occur regarding monitoring continence improvement/decline, and implementing toileting plans.</p> <p>Audit weekly for 4 weeks And monthly X 3 months to identify declines in urinary incontinence status and revision of care plan as needed.</p> <p><i>F315 POC accepted 12/4/14 BB/KA/AN/AMC</i></p>	

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F 315 Continued From page 9  
toilet upon awakening, after meals, nightly and as needed.

Per Activities of Daily Living (ADL) Record during the look back period, Resident #64 required extensive assistance of 1 or 2 staff members for toileting/transfer. Therefore, resident was dependent on staff to complete the toileting task and maintain continence.

F 315

Per interview on 11/5/14 at 12:10 PM with the Director of Nurses (DNS) and the Unit Manager (UM), both confirm that Resident #64's voiding pattern has not been thoroughly evaluated, nor has the type of incontinence the resident is experiencing been determined. The care plan has not been updated to reflect the change in urinary incontinence for Resident #64, as identified on the MDS assessment dated 9/30/14, nor has the resident received appropriate treatment to restore as much normal bladder function as possible.

F 356  
SS=C 483.30(e) POSTED NURSE STAFFING INFORMATION

F 356

The facility must post the following information on a daily basis:

- o Facility name.
- o The current date.
- o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
  - Registered nurses.
  - Licensed practical nurses or licensed vocational nurses (as defined under State law).
  - Certified nurse aides.
- o Resident census.

No residents were affected.

Staffing to be posted daily.

Education provided to Staffing Coordinator and HR Manager regarding posting requirements.

HR Manager to monitor daily, and report to CQI committee monthly for 3 months.

F356 POC accepted 12/4/14 B. Borden RN/PMC

11-25-14

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

PRINTED: 11/20/2014  
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  11/05/2014
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 9 HAYWOOD AVENUE RUTLAND, VT 05701
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(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
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F 356

Continued From page 10

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:

- o Clear and readable format.
- o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility failed to post the daily accurate nursing staff information in a prominent place readily accessible to all residents and visitors. Findings include:

During the initial tour upon entrance into the facility on 11/3/14 at 5:55 AM, the posting of the Daily Nurse Staffing Form was found to be in a hallway that consists of offices for facility staff. The posting was in a clear hard plastic holder that was at eye level for someone standing and it was posted outside the office door of the Nurse Practice Educator (NPE). The date on the posting was for 10/29/14. Per confirmation from the NPE at 6:45 AM, h/she confirmed, upon his/her arrival to the facility that the posting for staffing was dated for 10/29/14 and there was no evidence that there were any other postings with

F 356

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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>11/05/2014</b>
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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>
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(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
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F 356 Continued From page 11  
current dates. H/she also confirmed that the corridor where the posting is housed is in the Administrative Hallway which is not a main corridor used by all visitors or residents, that it is used by staff and sometimes visitors that go to Cherry Tree and Dogwood Drive. It is also utilized by Physical Therapy for ambulating residents. Per interview with the Human Resource Manager at 7:15 AM, h/she stated that it is their responsibility to post the Daily Nurse Staffing Form from Monday through Friday and the weekend supervisor posts the all staffing on Saturday and Sunday that h/she provides for them. There was no evidence of the postings other than the one dated 10/29/14 and confirmed by the NPE.

F 356

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM OR SNFs AND Nfs	PROVIDER #  475012	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/5/2014
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 9 HAYWOOD AVENUE RUTLAND, VT
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D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 387	<p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that 1 of 22 residents was seen at least once every 30 days after admission, Resident #168. Findings include:</p> <p>Per medical record review on 11/4/14 at 12:51 PM for Resident #168, it was noted that the resident was admitted to the facility on 9/12/14 from home. There was no evidence of physician progress notes in the medical records that indicated the resident had been seen prior to admission by a physician, nor was there evidence that a physician had been in to see the resident since admission to the facility. The Registered Nurse (RN), Unit Manager, verified that there was no evidence of physician progress notes at the time of discovery. The Director of Nursing (DON) stated that h/she may have evidence of a visit in his/her electronic record system and presented this surveyor with a copy of a progress note at 2:17 PM. Review of the physician progress note presented was dated 9/3/14 and signed by the Physician Assistant and not the physician. On 11/4/14 at 2:29 PM the Licensed Practical Nurse (LPN), during interview, stated that the resident was admitted to the facility on 9/12/14 for respite and when the daughter returned from vacation, the decision was made for the resident to remain in the facility for long term care. The LPN confirmed at the time of the interview that there was no evidence that the resident had been seen prior to admission by a physician and that there is no evidence in the medical record to indicate that the physician had visited within 30 days of admission.</p> <p>*This is an "A" level citation, which requires the facility to address the identified issue; however, no written plan of correction is required.</p>
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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

The above isolated deficiencies pose no actual harm to the residents