



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

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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

October 9, 2012

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

Dear Ms. Morton:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 22, 2012**. 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,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

PC:jl



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

PRINTED: 09/07/2012
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 08/22/2012
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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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F 279 Continued From page 1
comprehensive assessment. (Resident #163)
The findings include:

1. Per record review, Resident #163 was re-admitted to the facility on 07/27/12 for therapy services. Per review of Resident #163's comprehensive care plan, there was no evidence that a discharge care plan had been developed with measurable goals, objectives and interventions to meet the discharge needs of this resident. Per review of the comprehensive assessment there was a discharge goal to return to the community.

Per review of the progress notes from 07/27/12 to 08/21/12 with Social Services and the Assistant Director of Nursing (ADNS) on 08/21/12 at approximately 4:15 PM, they indicated that Resident #163 was at the facility for short term rehabilitation and the Resident had several medical set backs but the plan was for the Resident to continue rehabilitation and then potentially return home.

Per interview with the Assistant Director of Nursing on 08/21/12 at 5:00 PM, s/he confirmed that the discharge care plan that was provided to the surveyor for Resident #163 was created and revised on 8/21/12 and the date on the care plan was for the admission date of 07/27/12. The ADNS reviewed the care plan and confirmed that the goals and interventions on the discharge care plan provided to the surveyor indicated that the goals and interventions developed for Resident #163 were initiated and created on 08/21/12 by Social Services.

Per interview with the ADNS on 08/22/12 at 5:00

F 279

Social Service will monitor for care plan entries and report findings to CQI committee weekly x 4 then monthly for 3 months.

Oversight: Administrator

F279 POC accepted 10/5/12 PAVICTOR

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F 279	Continued From page 2 PM, s/he reviewed the care plans for Resident #163 that were developed prior to 08/21/12 and was unable to provide the surveyor with a discharge care plan developed after the admission date of 07/27/12 and prior to 08/21/12 care plan. Per interview with the ADNS on 08/22/12 at 5 PM, after review with the surveyor of the computerized medical record and care plans of Resident #179, the ADNS confirmed that there was no developed discharge care plan dated after the re-admission date of 07/27/12 and prior to the discharge care plan dated as created and initiated on 08/21/12.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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.	F 280	Resident #179 care plan was updated to reflect current plan of care. To ensure no other residents were affected care plans were audited to ensure they reflect current symptoms related to anxiety/behaviors. Education to be provided to licensed staff regarding care plan revisions related to anxiety/behaviors. Unit Managers will complete audits weekly x 4 then monthly for 3 months to ensure compliance. Report findings at CQI meeting.	9.21.12

F280 POC accepted 10/5/12 Pmedicare

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise the plan of care for 1 of 18 residents in the sample to reflect current symptoms related to anxiety/behaviors, specific goals, interventions, monitoring and documentation to address the residents specific needs. (Resident #179) Finding include: 1. Per record review on 08/22/12 at 8:00 AM, Resident #179 had a care plan dated 06/21/12 for psychoactive medication that stated to 'monitor for side effects related to mood, behavior as indicated, sadness/depression and anxiety'. Per review of the Medication Administration Record (MAR) the resident received Xanax (an anti-anxiety medication) 0.5 milligrams eight times during the month of August for anxiety. There was inconsistent documentation as to the reason given, response/effects or other interventions attempted. Per interview on 08/22/12 at 11:15 am, the Unit Manager confirmed that the care plan was an initial care plan and that it was not revised to specifically identify the sign/symptoms the resident displays, what other interventions the staff should have used or tried, and consistent monitoring of the effects of the medication.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	F281 Resident #146 was discharged. Resident #56 is currently stable and had no ill effects from the fall.	

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F 281	<p>Continued From page 4</p> <p>Based on record review and staff interview the facility failed to provide services that met professional standards of quality for two residents (Residents #146 and #56) regarding treatment of a wound and post-fall assessments. The findings include:</p> <p>1. Per record review, Resident #146 was admitted to the facility on 06/26/12 with diagnoses that included an open area on the right ankle. Per review of the treatment record for August, the August treatment record indicates that from 08/01/12 to 08/21/12 a Mesalt treatment was applied to the ankle wound and covered and changed daily. Per review of the medical record there was no evidence that an order was obtained for the Mesalt treatment from a physician or nurse practitioner.</p> <p>Per direct observation on 08/21/12 at approximately 10:20 AM, the treatment nurse was observed by the surveyor to remove the dressing from Resident #146's right ankle. The treatment nurse confirmed that per the treatment record the current order is for Mesalt to the right ankle wound daily and the dressing being removed from the right ankle of Resident #146 was Mesalt.</p> <p>Per interview with the Assistant Director of Nursing (ADNS) on 08/22/12 at approximately 10:30 AM, s/he reviewed the medical record in the physician's orders and was unable to locate an order by a physician or nurse practitioner to utilize Mesalt to the right ankle daily. The ADNS confirmed that the Mesalt was being applied to Resident #146 without a physician or nurse practitioner order. The ADNS also confirmed that the current order for treatment to the ankle wound</p>	F 281	<p>To ensure no other residents were affected, an audit will be performed to ensure all wound treatments have MD orders.</p> <p>Licensed staff to receive education regarding neurological/post-fall assessment and obtaining physician orders for wound treatments.</p> <p>Unit Mangers will complete audits weekly x 4 then monthly for 3 months to ensure compliance. Report findings at CQI meeting.</p> <p>Oversight: DNS</p> <p><i>FBI POC accepted 10/5/12 - Pmedstar</i></p>	9.21.12

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F 281	<p>Continued From page 5 was Santyl written on 07/17/12.</p> <p>See also F282.</p> <p>2. Per record review, Resident #56, whose diagnoses include altered mental status, senile dementia, and who has a history of falls, had an unwitnessed fall in h/her room on 8/18/12 at 10:00 A.M. Per record review on 8/21/12 of the facility's policy - Assessment: Neurological - "When a patient sustains an injury to the head and/or has an unwitnessed fall, neurological assessment will be performed: every 30 min. x one hour, then every one hour x four hours, then every four hours x 24 hours." Additionally, per record review of the facility's Fall Response Protocol, after a fall "Evaluate and monitor resident for 72 hours...evaluate patient's level of consciousness and vital signs."</p> <p>Per 'Resident Assessment And Monitoring for Long-term Care: Essential Tools And Guidelines for Clinicians' - "The standard of long term care nursing practice requires monitoring of residents with known or suspected head injury for a minimum of 72 hours...the assessment should include, at a minimum, pulse, respirations, and blood pressure measurements." (1)</p> <p>Per interview on 8/22/12 at 5:31 P.M. Resident #56's Unit Manager (UM) confirmed that after h/her unwitnessed fall, Resident #56's Neurological Assessment sheet lists neurological and vital signs recorded twice the first hour, then four more times over the next 9 hours, then were stopped. The UM confirmed this did not follow the facility policy regarding the first 24 hours, and that neurological checks and vital signs should have</p>	F 281		
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F 281	<p>Continued From page 6</p> <p>continued on each shift over 72 hours per the policy. The UM confirmed the next vital signs taken of Resident #56 were 2 days later on 8/20/12 at 9:03 A.M. The Unit Manager stated it was h/her expectation that Resident #56 would be monitored per the facility's fall policy and protocol but was not.</p> <p>References: (1) Acello, Barbara. " Neurological Assessment " Resident Assessment and Monitoring for Long Term Care-Essential tools and Guidelines for Clinicians. Marblehead, MA : HCPro, ©2006. August 2012 http://www.worldcat.org/title/resident-assessment-and-monitoring-for-long-term-care-essential-tools-and-guidelines-for-clinicians/oclc/98449310/viewport</p> <p>Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.</p>	F 281		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide services by qualified persons in accordance with each resident's written care plan for one resident applicable</p>	F 282		

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F 282	<p>Continued From page 7</p> <p>resident in the sample(Resident #146). The findings include:</p> <p>1. Per record review, Resident #146 was admitted to the facility on 06/26/12 with diagnoses that included an open area on the right ankle. Per review of the treatment records for August 2012, the August treatment record indicates that from 08/01/12 to 08/21/12 a Mesalt treatment was applied to the right ankle wound and covered and changed daily. Per review of the medical record there was no evidence that an order was obtained for the Mesalt treatment from a physician or nurse practitioner.</p> <p>Per direct observation on 08/21/12 at approximately 10:20 AM, the treatment nurse was observed by the surveyor to remove the dressing from Resident #146's right ankle. The treatment nurse confirmed that per the treatment record the current ordered treatment for the right ankle wound was Mesalt to be applied to area on the ankle daily then covered and the dressing removed from the right ankle of Resident #146 was Mesalt.</p> <p>Per review of the comprehensive care plan for Resident #146 titled: "resident has actual skin breakdown related to vascular disease, venous ulcer on right lateral leg" the intervention initiated on 08/13/12 indicates to "provide wound treatment as ordered."</p> <p>Per interview with the Assistant Director of Nursing (ADNS) on 08/22/12 at approximately 10:30 AM, s/he reviewed the medical record in the physician's orders and was unable to locate an order by a physician or nurse practitioner to</p>	F 282	<p>Resident #146 was discharged.</p> <p>To ensure no other residents were affected, An audit will be performed to ensure all wound treatments have MD orders.</p> <p>Licensed staff to receive education regarding obtaining physician orders for wound treatments</p> <p>Unit managers will complete audits weekly x 4 then monthly for 3 months to ensure compliance. Report findings at CQI meeting.</p> <p>Oversight: DNS</p> <p><i>1382 POC accepted 10/5/12 Pmedstaff</i></p>	<i>9.21.12</i>

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F 282 Continued From page 8
utilize Mesalt to the right ankle daily. The ADNS confirmed that the Mesalt was being applied to Resident #146 without a physician or nurse practitioner order. The ADNS confirmed that the current order for treatment to the ankle wound was an order for Santyl written on 07/17/12.

F.282