

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

June 28, 2012

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

Provider #: 475012

Dear Ms. Morton:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **April 30, 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,



Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure - This version replaces the existing Accepted POC (survey date 4/30/12) with cover letter dated June 4, 2012.



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

RECEIVED
Division of
JUN 21 12
PRINTED: 06/18/2012
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 _____ <i>Licensing and Protection</i>	(X3) DATE SURVEY COMPLETED C 04/30/2012
--------------------------------------------------	-------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------	----------------------------------------------------------

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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 000	INITIAL COMMENTS	F 000	The Center's filing of this plan of correction does not constitute an admission to any of the alleged citations set forth in this statement of deficiency. The Center files this plan of correction as evidence of the Center's continued compliance with all applicable federal and state laws and regulations.	
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that 1 resident identified (Resident #1) received the right to choose health care services consistent with his/her assessments and plan of care and the right to make choices about aspects of his/her life in the facility that are significant to the resident. The findings include:</p> <p>1. Per review of the medical record, Resident #1 was admitted on 1/10/12 for short term rehabilitation after a surgical repair of a rectal prolapse and colectomy with colostomy and was to be discharged to home. Review of the MDS (comprehensive assessment) dated 1/18/12 indicated that Resident #1 was alert and oriented with a BIMS (Brief Interview for Mental Status) score of 12 and able to make his/her own choices. Review of Resident #1's medical</p>	F 242	<p>242 Resident #1 no longer resides in facility.</p> <p>In order to identify other patients who may be affected, the center will audit records of patients identified which is incorporated in the expanded nursing assessment.</p> <p>Licensed staff will receive education regarding resident's rights and the right to self determination.</p>	<p>5-31-12</p> <p>6-13-12</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Quilley Newton</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6-19-12</i>
------------------------------------------------------------------------------------------------	-------------------------------	-----------------------------

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.

Pme

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

PRINTED: 06/18/2012
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 C 04/30/2012
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	
F 242	<p>Continued From page 1</p> <p>diagnoses, there was no evidence of a diagnosis of dementia or cognitive impairment. Review of the Psychiatric notes dated 1/31/12, 2/14/12 and 2/15/12 there was no evidence that Resident #1 had any diagnosis of impaired cognition or any indication that Resident #1 was not able to make his/her own decisions. Per review of the Nurse Practitioner's (NP) progress note dated on 1/13/12, Resident #1 was alert and oriented, there was no evidence in the NP or physician's notes indicating that Resident #1 was cognitively impaired or not able to make his/her own decisions.</p> <p>Per review of the Social Service (SS) notes dated 2/13/12, Resident #1 expressed to his/her spouse that he/she was leaving the facility and walked away. The notes indicated that the Social Worker (SW) and a floor nurse attempted to place a secure care bracelet (device to alert staff when a resident leaves the building) on Resident #1, but that he/she was able to remove it (indicating the resident did not wish to have the secure care device placed). Review of the skilled nursing notes dated 2/18/12 the secure care remains off at this time. Review of the general notes dated 2/20/12 a secure care device was placed on the residents walker. Review of the skilled nursing notes dated 2/21/12 indicates: secure care on walker for patient compliance. Per review of the comprehensive care plan there was no evidence of the utilization of a secure care bracelet for Resident #1. Per review of the facility assessments there was no evidence that the resident was assessed for the need of a secure care bracelet for exit seeking behavior.</p> <p>Per interview on 4/30/12 at 11:10 AM with the</p>	F 242	<p>Nurse Managers will report to the DNS if patients refuse secure care devices so alternative safety measures can be put in place.</p> <p>The DNS will report refusals to the CQI Committee. The CQI Committee will evaluate for further recommendations.</p> <p>Oversight: DNS</p> <p><i>F242 POC accepted 6/21/12 Amotaran</i></p>	<i>6/17/12</i>	

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

PRINTED: 06/18/2012
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 C 04/30/2012
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	
F 242	Continued From page 2 facility Administrator and Director of Nursing Services (DNS), they indicated that the facility has no formal assessment tool to determine if a resident is in need of secure care monitoring device. The DNS indicated the the decision to utilize a secure care bracelet on a resident was determined by the staff present at the time and the circumstances involved in the specific residents issues. The DNS indicated that the secure care bracelet was a device to alert staff on a residents attempt to leave the building. That an alarm sounds letting staff know a resident at risk for safety issues has left the facility. The DNS indicated that the resident is not asked prior to initiation or educated on the purpose of the secure care bracelet.	F 242			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide medically related Social Services to maintain the highest practicable physical, mental and psychosocial well-being of 1 resident identified (Resident #1). The findings include: 1. Per review of the medical record Resident #1 was admitted on 1/10/12 for short term rehabilitation after a surgical repair of a rectal	F 250	250 Resident #1 no longer resides in facility Other residents with adjustment reactions have the potential to be affected. Licensed nurses and Social Work staff will be educated by the Regional Social Work consultant regarding plan of care documentation for adjustment reactions The center will audit current residents admitted in the past 30 days for signs and symptoms of adjustment disorders and then monthly x 3.	6-10-12	

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

PRINTED: 06/18/2012
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 C 04/30/2012	
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
F 250	<p>Continued From page 3</p> <p>prolapse and colectomy with colostomy. Other admitting diagnoses include depression, pulmonary hypertension, seizures, ulcerative colitis, anemia, arthritis, celiac disease, chronic renal insufficiency, glucose intolerance, hypothyroidism, irritable bowel syndrome, and osteoporosis. Per the Social Service (SS) notes dated 2/7/12, Resident #1 was moved to the Bwing (long term care unit) and told that she would not be discharging to home as Resident #1 expected because the resident's spouse was unable to meet Resident #1's needs at home.</p> <p>Per the Skilled Nursing notes dated 2/13/12, Resident #1 spoke with SS and indicated that he/she was leaving. SS spoke with the spouse and the spouse indicated that Resident #1 struck him and was "talking crazy". SS told the spouse that the resident "would not be safe to go home the way he/she is now and that Resident #1 had a recent fall". Per skilled nursing notes dated 2/14/12, Resident #1 had an "episode of exit seeking when spouse came to visit and SS placed a secure care bracelet on Resident #1 who was able to remove it, and that Resident #1 was highly agitated."</p> <p>Per review of the Psychiatric notes dated 1/31/12 Resident #1 was referred to assess depression. The note dated 1/31/12, that Resident #1 "tends to be a nervous person and he/she wants to go home." The notes also indicate that Resident #1 indicated "he/she was not sleeping well" "due to the noisy environment" and that he/she "is use to a quiet environment and that [Resident #1] feels he/she will be fine once he/she is home and that [Resident #1] does not feel the need for counseling at this time." Per review of the</p>	F 250	<p>The results of these audits will be reported by the Administrator to the CQI Committee. The CQI Committee will evaluate for further recommendations.</p> <p>Oversight: Administrator</p> <p><i>F250 POC accepted 6/29/12 Amcotarw</i></p>	

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

PRINTED: 06/18/2012
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 C 04/30/2012
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	
F 250	<p>Continued From page 4</p> <p>Psychiatric follow-up dated 2/14/12, the notes indicate that Resident #1 stated he/she felt that he/she was "having a nervous breakdown" and that the resident had tried to leave the building with his/her spouse. The notes also indicate that Resident #1 is "alert and oriented but distressed at being at the nursing home" and in Resident #1's mind there is no reason he/she can not go home. The note also indicates that psychiatry doubted that any medication changes would be helpful, that Resident #1 was "reacting to the situation" and diagnosed Resident #1 with "Adjustment reaction with mixed emotional features".</p> <p>Per the SS notes dated 2/15/12, SS was made aware that Resident #1 made a comment about suicide. The resident confirmed with SS that he/she had made a comment and SS asked if Resident #1 had a plan to harm him/herself and Resident #1 indicated "no, not at this time." The physician notes dated 2/16/12 indicate that the difficult behaviors are likely adjustment behaviors. Per review of the progress notes there was no evidence that after 2/15/12 that the residents "adjustment reaction and mixed emotional features" were addressed by SS. There is no evidence that Resident #1 had any further meetings with Psychiatry services after 2/15/12.</p> <p>Per review of the comprehensive care plan, there was no evidence that the "adjustment reaction with emotional features" and the suicidal comment by Resident #1 were addressed and a plan created and interventions put into place to assist Resident #1 with his/her adjustment behaviors and comments on potential suicide and safety. Per review of the MDS dated 1/18/12,</p>	F 250			

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

PRINTED: 06/18/2012
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 C 04/30/2012
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------------------

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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 250	<p>Continued From page 5</p> <p>Resident #1 was alert, had a BIMS scale of 12, had no noted behaviors and no acute mental status changes. Per review of the medical record there was no indication that Resident #1 was diagnosed with any cognitive impairment and was able to make decisions independently.</p> <p>Review of the care plan titled " Risk for complications to the use of psychotropic drugs for treatment of depressive disorder" with the Administrator, DNS and Social Service Director (SSD) dated 1/30/12 indicated the following interventions: Monitor for changes in mental status and functional level and report to MD as indicated, monitor for continued need of the medication as related to behavior and moods and monitor for side effects and consult physician and or pharmacist as needed. Per review of the care plan titled "Admission of the resident is anticipated to have a length of stay less than 90 days" with the Administrator and DNS the interventions were: Allow resident to discuss feelings regarding discharge, encourage resident/family to participate in plan of care and provide clear expectations and feedback on performance. Per interview with the Administrator and DNS on 4/30/12 at 11:10 AM, they indicated that the care plans titled " Risk for complications to the use of psychotropic drugs for treatment of depressive disorder" and "Admission of the Resident is anticipated to have a length of stay less than 90 days", had interventions that met the needs of Resident #1's adjustment behaviors, suicidal comment and discharge.</p> <p>Per interview with the SSD on 4/30/12 at 11:10 AM, he/she indicated that he/she was aware of the psychiatric consultations and there was no</p>	F 250		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 06/18/2012
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 C 04/30/2012
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
F 250	Continued From page 6 care plan created to deal with Resident #1's "adjustment reaction and emotional features" and suicidal comments because the resident was going to go home which is what he/she wanted and that Resident #1 had indicated she did not have a plan so there was no need to address any safety concerns or the resident's statement. The SSD indicated that they had "allowed the visit of the residents dog" after SSD was informed by the resident he/she missed the dog and that the facility had requested that spouse not visit because Resident#1's behaviors increased with the spouses visits. The SS notes dated 2/13/12 indicated that Resident #1 expressed he/she was leaving and that a SW and a nurse attempted to place a secure care bracelet on Resident #1, but that Resident #1 was able to get the bracelet off. Per interview with the Administrator, SSD and DNS on 4/30/12 they indicated that a secure care bracelet was placed on a resident at the discretion of the team member at the time of the incident and that the bracelet was utilized to alert staff at a residents attempt to leave the building and that no one had educated or obtained consent from Resident #1 to place the secure care bracelet on Resident #1. The Administrator and DNS also indicated that the plan was to discharge Resident #1 as the resident wanted and felt that the intervention of discharge met the needs of Resident #1. Resident #1 left the facility with his/her spouse "against medical advice" on 2/27/12 and did not return.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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

PRINTED: 06/18/2012
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 C 04/30/2012
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	
F 279	<p>Continued From page 7 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive care plan for 1 resident (Resident #1) identified as having adjustment behaviors and suicidal comments. The findings include:</p> <p>1. Per review of the medical record, Resident #1 was admitted on 1/10/12 for short term rehabilitation after a surgical repair of a rectal prolapse and colectomy with colostomy. Other admitting diagnoses include depression, pulmonary hypertension, seizures, ulcerative colitis, anemia, arthritis, celiac disease, chronic renal insufficiency, glucose intolerance, hypothyroidism, irritable bowel syndrome, and osteoporosis. Per review of the progress notes,</p>	F 279	<p>279 Resident #1 no longer resides in facility</p> <p>Other residents with adjustment reaction and or suicidal ideation have the potential to be affected.</p> <p>Licensed Nurses and Social Work staff to be educated by the Regional Social Work consultant on documenting the plan for addressing patients with Adjustment reactions and or suicidal ideations.</p> <p>Center will audit any residents with an adjustment disorder to ensure there is a care plan identifying residents needs monthly x 3.</p> <p><i>F279 POC accepted 4/27/12 Annotate</i></p>	<i>6-10-12</i>	

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

PRINTED: 06/18/2012
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 C 04/30/2012
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
F 279	<p>Continued From page 8</p> <p>Resident #1 was to receive therapy services with a goal of reaching his/her pre-hospitalization level of functioning and then return to his/her home with his/her spouse. Per the Care Plan Meeting notes dated 1/24/12, a discussion took place with Resident #1 and his/her spouse and family regarding the families expressed concern that the spouse may not be able to meet the needs of Resident #1 at home and concern that Resident #1 had some memory issues and the family was looking into other options like Assisted Living.</p> <p>Per the Social Service (SS) notes dated 2/7/12, Resident #1 was moved to the Bwing (long term care unit) and told that she would not be discharging to home as Resident #1 expected because the resident's spouse was unable to meet Resident #1's needs at home. Per the Skilled Nursing notes dated 2/13/12, Resident #1 spoke with SS and indicated that he/she was leaving the facility. SS spoke with the spouse and the spouse indicated that Resident #1 struck him and was "talking crazy". SS told the spouse that Resident #1 would not be safe to go home the way he/she is now and that Resident #1 had a recent fall. Per skilled nursing notes dated 2/14/12, Resident #1 had an "episode of exit seeking when spouse came to visit and [Resident #1] was highly agitated."</p> <p>Per review of the Psychiatric follow-up dated 2/14/12, the notes indicate that Resident #1 stated "he/she felt that he/she was having a nervous breakdown" and that Resident #1 had tried to leave the building with his/her spouse. The notes also indicate that Resident #1 is alert and oriented but distressed at being at the nursing home and in Resident #1's mind there is</p>	F 279		

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

PRINTED: 06/18/2012
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 C 04/30/2012
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	
F 279	<p>Continued From page 9</p> <p>no reason he/she can not go home. The Psychiatric notes dated 2/15/12 indicate that a conversation occurred with SS regarding the family situation and the current feeling that the spouse for Resident #1 cannot manage the care at home for Resident #1. The note also indicates that psychiatry doubted that any medication changes would be helpful, that Resident #1 was reacting to the situation and diagnosed Resident #1 with Adjustment reaction with mixed emotional features.</p> <p>Per the SS notes dated 2/15/12, SS was made aware that Resident #1 made a comment about suicide. The resident confirmed with SS that he/she had made a comment and SS asked if Resident #1 had a plan to harm him/herself and Resident #1 indicated "no, not at this time." The physician notes dated 2/16/12 indicate that the "difficult behaviors is likely adjustment behaviors." Per review of the comprehensive care plan there was no evidence indicating that the "adjustment reaction with emotional features" and the suicidal comment by Resident #1 were addressed and a plan created and interventions put into place to assist Resident #1 with his/her adjustment behaviors and comments on potential suicide and safety. Per review of the MDS (comprehensive assessment) dated 1/18/12, resident #1 was alert, had a BIMS scale of 12, had no noted behaviors and no acute mental status changes. Per review of the record there was no indication that Resident #1 was diagnosed with any cognitive impairment and was able to make decisions independently.</p> <p>Per interview with the Administrator and Director of Nursing on 4/30/12 at 11:10 AM, they indicated</p>	F 279			

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

PRINTED: 06/18/2012
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 C 04/30/2012
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
F 279	<p>Continued From page 10</p> <p>that the care plan titled "Risk for complications to the use of psychotropic drugs for treatment of depressive disorder", had interventions that met the needs of Resident #1's adjustment behaviors and suicidal comment. Review of the care plan with the Administrator, DNS and SSD dated 1/30/12 indicated the following interventions: Monitor for changes in mental status and functional level and report to MD as indicated, monitor for continued need of the medication as related to behavior and moods and monitor for side effects and consult physician and or pharmacist as needed.</p> <p>Per interview with the Social Service Director (SSD) on 4/30/12 at 11:10 AM, he/she indicated that there was no care plan created to deal with Resident #1's "adjustment reaction and emotional features" and suicidal comments because the resident was going to go home which is what he/she wanted and that Resident #1 had indicated she did not have a plan so there was no need to address any safety concerns or the residents statement. Per interview on 4/30/12 at 11:10 AM the Administrator and DNS also indicated that the plan was to so discharge Resident #1 as the resident wanted and felt that the intervention of discharge met the needs of Resident #1. Resident #1 left the facility with his/her spouse "against medical advice" on 2/27/12 and did not return.</p>	F 279		
F 319 SS=D	<p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and</p>	F 319		

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

PRINTED: 06/18/2012
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 C 04/30/2012
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	
F 319	<p>Continued From page 11 services to correct the assessed problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that 1 resident (Resident #1) who was displaying mental and psychosocial adjustment difficulties received appropriate treatment and services to correct the problem The findings include:</p> <p>1. Per review of the medical record, Resident #1 was admitted on 1/10/12 for short term rehabilitation after a surgical repair of a rectal prolapse and colectomy with colostomy. Other admitting diagnoses include depression, pulmonary hypertension, seizures, ulcerative colitis, anemia, arthritis, celiac disease, chronic renal insufficiency, glucose intolerance, hypothyroidism, irritable bowel syndrome, and osteoporosis.</p> <p>Per the Social Service (SS) notes dated 2/7/12, Resident #1 was moved to the B Wing (long term care unit) and told that she would not be discharging to home as Resident #1 expected because the resident's spouse was unable to meet Resident #1's needs at home. Per the Skilled Nursing notes dated 2/13/12, Resident #1 spoke with SS and indicated that he/she was leaving. SS spoke with the spouse and the spouse indicated that Resident #1 struck him and was "talking crazy". SS told the spouse that the resident would not be safe to go home the way he/she is now and that Resident #1 had a recent fall. Per skilled nursing notes dated 2/14/12, Resident #1 had an "episode of exit seeking</p>	F 319	<p>319 Resident #1 no longer resides in facility.</p> <p>Social Work staff to be educated by the Regional Social Work consultant on documenting the plan for addressing patients with Adjustment reactions and or suicidal ideations</p> <p>In order to identify other patients who may be affected, the SW staff will conduct an audit of patients seen by psych services and ensure care plans are in place for any patient with adjustment reaction and or suicidal ideation monthly for 3 months.</p>	5-29-12	

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

PRINTED: 06/18/2012
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 C 04/30/2012
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
F 319	<p>Continued From page 12</p> <p>when spouse came to visit and SS and a floor nurse placed a secure guard on [Resident #1] who was able to remove it" and that Resident #1 was highly agitated.</p> <p>Per review of the Psychiatric notes dated 1/31/12 Resident #1 was referred to assess depression. That Resident #1 "tends to be a nervous person and he/she wants to go home". The notes also indicate that Resident #1 indicated "he/she was not sleeping well" due to the noisy environment and that he/she is use to a quiet environment and that Resident #1 feels he/she will be fine once he/she is home and that Resident #1 does not feel the need for counseling at this time. Per review of the Psychiatric follow-up dated 2/14/12, the notes indicate that Resident #1 stated he/she felt that he/she was "having a nervous breakdown", and that the resident had tried to leave the building with his/her spouse. The notes also indicate that Resident #1 is alert and oriented but distressed at being at the nursing home and in Resident #1's mind there is no reason he/she can not go home. The note also indicates that psychiatry doubted that any medication changes would be helpful, that Resident #1 was reacting to the situation and diagnosed Resident #1 with "Adjustment reaction with mixed emotional features".</p> <p>Per the SS notes dated 2/15/12, SS was made aware that Resident #1 made a comment about suicide. The resident confirmed with SS that he/she had made a comment and SS asked if Resident #1 had a plan to harm him/herself and Resident #1 indicated "no, not at this time." The physician notes dated 2/16/12 indicate that the difficult behaviors are likely adjustment behaviors.</p>	F 319	<p>The results of these audits will be reported by the Administrator to the CQI Committee. The CQI Committee will evaluate for further recommendations.</p> <p>Oversight: Administrator</p> <p><i>F319 POC accepted 6/27/12 Amcot/PW</i></p>	

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

PRINTED: 06/18/2012
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 C 04/30/2012
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------------------

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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 319	<p>Continued From page 13</p> <p>Per review of the progress notes there was no evidence that after 2/15/12 that the resident's adjustment reaction and mixed emotional features were addressed by SS. There is no evidence that Resident #1 had any further meetings with Psychiatry services. Per review of the comprehensive care plan indicated there was no evidence that the "adjustment reaction with emotional features" and the suicidal comment by Resident #1 were addressed and a plan created and interventions put into place to assist Resident #1 with his/her adjustment behaviors and comments on potential suicide and safety. Per review of the MDS (comprehensive assessment) dated 1/10/12, Resident #1 was alert, had a BIMS scale of 18, had no noted behaviors and no acute mental status changes. Per review of the record there was non indication that Resident #1 was diagnosed with any cognitive impairment and was able to make decisions independently.</p> <p>Per interview with the Administrator and Director of Nursing on 4/30/12 at 11:10 AM, they indicated that the care plan titled "Risk for complications to the use of psychotropic drugs for treatment of depressive disorder", had interventions that met the needs of Resident #1's adjustment behaviors and suicidal comment. Review of the care plan with the Administrator, DNS and SSD dated 1/30/12 indicated the following interventions: Monitor for changes in mental status and functional level and report to MD as indicated, monitor for continued need of the medication as related to behavior and moods and monitor for side effects and consult physician and or pharmacist as needed.</p> <p>Per interview with the Social Service Director on</p>	F 319		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 06/18/2012
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 C 04/30/2012
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	
F 319	Continued From page 14 4/30/12 at 11:10 AM, he/she indicated that he/she was aware of the psychiatric consultations and there was no care plan created to deal with Resident #1's "adjustment reaction and emotional features" and suicidal comments because the resident was going to go home which is what he/she wanted and that Resident #1 had indicated she did not have a plan so there was no need to address any safety concerns or the residents statement. The SSD indicated that they had "allowed the visit of the residents dog" after SSD was informed by the resident he/she missed the dog and that the facility had requested that spouse not visit because Resident #1's behaviors increased with the spouse's visits. The SS notes dated 2/13/12 indicated that Resident #1 expressed he/she was leaving and that a "Social Worker and a nurse attempted to place a secure care bracelet on [Resident #1], but that [Resident #1] was able to get the bracelet off". Per interview with the Administrator, SSD and DNS on 4/30/12 they indicated that a secure care bracelet was placed on a resident at the discretion of the team member at the time of the incident and that were utilized to alert staff at a residents attempt to leave the building and that no one had educated or received consent for Resident #1 to place the secure care on Resident #1. The Administrator and DNS also indicated in interview on 4/30/12 that the plan was to discharge Resident #1 as the resident wanted and felt that the intervention of discharge met the needs of Resident #1. Resident #1 left the facility with his/her spouse "against medical advice" on 2/27/12 and did not return.	F 319			