

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

July 6, 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 **June 13, 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



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

PRINTED: 06/26/2012
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 06/13/2012
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 201	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to permit one applicable resident (Resident #1) to remain in the facility and not be transferred or discharged from the facility unless the discharge is necessary for the resident's welfare and the resident's needs cannot be met by the facility. The findings include: 1. Per record review on 6/13/12, Resident #1 was admitted to the facility on 5/23/12 for short term rehabilitation. Resident #1's diagnosis included; Dementia, atrial fibrillation, syncope with falls, and orthostatic hypotension. The Nurses Notes (NN) indicate that Resident #1 had a rapid progression in his/her dementia, was unable to remain at home and had numerous hospitalizations. Per review of the facility physicians progress note dated 5/24/12, the physician indicated that Resident #1 had new onset dementia that was progressing rapidly. Resident #1 was noted to be in need of long term living situation because Resident #1 was non compliant with care and medications when at home and that Resident #1's spouse also had significant memory loss and this complicated the care at home. Per Social Service (SS) notes on 5/24/12 at 2:55 PM, Resident #1 was moved to the secure dementia unit and a secure care bracelet was applied related to Resident #1's verbalization of wanting to leave the facility. Per NN dated 5/25/12 at 7:00 PM, Resident #1 became agitated, with an increase in exit seeking behaviors when husband was at facility visiting Resident #1. The NN indicate that on 5/25/12 at 8:50 PM, Resident #1	F 201	Center staff will be educated on policy and regulation of discharges being initiated by facility. Oversight: Administrator F201 POC accepted 7/3/12 McLennan RN / Pmc		

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

PRINTED: 08/26/2012
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 06/13/2012
--	--	--	---

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)	(X6) COMPLETION DATE
F 201	<p>Continued From page 2</p> <p>was exhibiting increased exit seeking behavior, refusing to eat, family was in visiting and needed to be distracted by staff so family could leave the facility. Per NN on 5/26/12 at 9:12 AM, Resident #1 was "asking to leave". The NN indicate that Resident #1 was displaying increased exit seeking behavior, stating that he/she was going to "call the police" and stating "I don't live here." The NN also indicate that Resident #1 was "standing watching exit doors for someone to open them." Per NN, Resident #1 placed on 15 minute checks and secure care bracelet was in place.</p> <p>Per the NN dated 5/26/12 at 6:14 PM, Resident #1 continues on 15 minute monitoring, Resident #1 agitated, exiting seeking pacing the halls and Resident #1 was in dining room looking out the window. Staff reported 10 minutes later Resident #1 could not be found. Administrator and police were notified. Resident #1 was returned to facility by local police. Resident #1's secure care bracelet was found on the ground, outside Resident #1's bedroom window. Resident #1 was evaluated by the Nurse Practitioner (NP) on 5/26/12 and no injuries were found. Resident #1 stated that he/she would leave again if he/she needed to.</p> <p>On 5/26/12 Resident #1's family met with the NP and staff nurse and were informed by the NP that the facility Administrator had indicated that the family needed to take resident home, and that the Administrator had indicated that the facility could not meet the needs of Resident #1. Per NN, medications were reviewed with the family and Resident #1 and family left the facility that same evening. Per review of the medical record there was no evidence that Resident #1 or Resident</p>	F 201		

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

PRINTED: 06/26/2012
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 06/13/2012
--	---	--	---

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 201	Continued From page 4 inform the family that Resident #1 had to be discharged from the facility because of the resident's "intense desire to leave, physical ability to leave the building and statements made by [Resident #1] that he/she would do it again, and that the facility could not ensure [Resident #1's] safety." The Administrator and DNS confirmed that no written notice of discharge was provided to Resident #1 or his/her family prior to discharge indicating when, why and where Resident #1 would be discharged and that Resident #1 was not provided with education of his/her rights regarding discharge and ability to challenge the discharge decision.	F 201		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more	F 203	Resident #1 was discharged home under the care of her family. No other residents have been discharged at the direction of the facility. Center will audit discharges that the facility initiates to ensure education and written notice of discharge is provided to resident/responsible party on their rights to appeal and the resident's ability to remain in facility during the appeal process. Audits will be brought to CQI monthly x 3	6-28-12

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

PRINTED: 06/26/2012
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 06/13/2012
--	--	--	---

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 203	<p>Continued From page 5</p> <p>immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide written notice of involuntary discharge of one resident (Resident #1) from the facility and failed to ensure that the resident understood their right to appeal the action to the State. The findings include:</p>	F 203	<p>Center staff will be educated on policy and regulation of discharges being initiated by facility.</p> <p>Oversight: Administrator</p> <p>F203 POC accepted 7/3/12 McLuhhan RN/ PNC</p>	6-28-12
-------	---	-------	---	---------

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

PRINTED: 08/26/2012
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 06/13/2012
--	--	--	---

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 203	<p>Continued From page 6</p> <p>1. Per record review on 6/13/12, Resident #1 was admitted to the facility on 5/23/12 for short term rehabilitation. Resident #1's diagnosis included; Dementia, atrial fibrillation, syncope with falls, and orthostatic hypotension. The Nurses Notes (NN) indicate that Resident #1 had a rapid progression in his/her dementia and was unable to remain at home and had numerous hospitalizations.</p> <p>Per the NN dated 5/26/12 at 6:14 PM, Resident #1 continues on 15 minute monitoring, Resident #1 agitated, exiting seeking pacing the halls and Resident #1 was in dining room looking out the window. Staff reported 10 minutes later Resident #1 could not be found. Administrator and police were notified. Resident #1 was returned to facility by local police. Resident #1's secure care bracelet was found on the ground, outside Resident #1's bedroom window. Resident #1 was evaluated by the Nurse Practitioner (NP) on 5/26/12 and no injuries were found. Resident #1 stated that he/she would leave again if he/she needed to. On 5/26/12 Resident #1's family met with the NP and staff nurse and were informed by the NP that the facility Administrator had indicated that the family needed to take resident home that the Administrator had indicated that the facility could not meet the needs of Resident #1. Per NN medications were reviewed with the family and Resident #1 and family left the facility that same evening. Per review of the medical record there was no evidence that Resident #1 or Resident #1's family received any education or paperwork regarding why Resident #1 was being discharged from the facility and Resident #1's rights regarding challenging the discharge decision.</p> <p>Per interview with on 6/13/12 at 11:15 AM with</p>	F 203		
-------	--	-------	--	--

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

PRINTED: 06/26/2012
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 06/13/2012
--	--	--	---

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 203	Continued From page 7 the facility Administrator, Director of Nursing Services (DNS), Social Service Director (SSD), Social Service Worker (SSW) and Admission Coordinator (AC) the facility Administrator confirmed that he/she gave the directive via telephone on 5/26/12 to the NP to inform the family that Resident #1 had to be discharged from the facility because of the resident's "intense desire to leave, physical ability to leave the building and statements made by [Resident #1] that he/she would do it again, and that the facility could not ensure [Resident #1's] safety." The Administrator and DNS confirmed that no written notice of discharge was provided to Resident #1 or his/her family prior to discharge indicating when, why and where Resident #1 would be discharged and that Resident #1 was not provided with education of his/her rights regarding discharge and ability to challenge the discharge decision.	F 203		
F9999	FINAL OBSERVATIONS 3.14 Transfer and Discharge (g) Discharge to community setting. No resident appropriate for nursing home care may be discharged to a community setting against his or her will. A facility must document that a resident voluntarily discharged to a community setting understood fully all options for care and understood fully the right to refuse such a discharge. The REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview the facility failed to document and assure that a	F9999		

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

PRINTED: 06/26/2012
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 06/13/2012
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
F9999	Continued From page 8 resident discharged to a community setting understood fully all options for care and understood fully the right to refuse such a discharge for one resident (Resident #1). The findings include: 1. Per record review on 6/13/12, Resident #1 was admitted to the facility on 5/23/12 for short term rehabilitation. Resident #1's diagnosis included; Dementia, atrial fibrillation, syncope with falls, and orthostatic hypotension. The Nurses Notes (NN) indicate that Resident #1 had a rapid progression in his/her dementia and was unable to remain at home and had occurred numerous hospitalizations. Per the NN dated 5/26/12 at 6:14 PM, Resident #1 continues on 15 minute monitoring, Resident #1 agitated, exiting seeking pacing the halls and Resident #1 was in dining room looking out the window. Staff reported 10 minutes later Resident #1 could not be found. Administrator and police were notified. Resident #1 was returned to facility by local police. Resident #1's secure care bracelet was found on the ground, outside Resident #1's bedroom window. Resident #1 was evaluated by the Nurse Practitioner (NP) on 5/26/12 and no injuries were found. Resident #1 stated that he/she would leave again if he/she needed to. On 5/26/12 Resident #1's family met with the NP and staff nurse and were informed by the NP that the facility Administrator had indicated that the family needed to take resident home that the Administrator had indicated that the facility could not meet the needs of Resident #1. Per NN medications were reviewed with the family and Resident #1 and family left the facility that same evening. Per review of the medical record there	F9999	Resident #1 was discharged home under the care of her family. No other residents have been discharged at the direction of the facility. Center will audit discharges that the facility initiates to ensure education and written notice of discharge is provided to resident/responsible party on their rights to appeal and the resident's ability to remain in facility during the appeal process. Audits will be brought to CQI monthly x 3 Center staff will be educated on policy and regulation of discharges being initiated by facility. Oversight: Administrator F9999 POC accepted 7/3/12 McLellan RN / PNC	6-28-12

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

PRINTED: 06/26/2012
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 06/13/2012
--	--	--	---

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

F9999	<p>Continued From page 9</p> <p>was no evidence that Resident #1 or Resident #1's family received any education or paperwork regarding why Resident #1 was being discharged from the facility and Resident #1's rights regarding challenging the discharge decision.</p> <p>Per interview with on 6/13/12 at 11:15 AM with the facility Administrator, Director of Nursing Services (DNS), Social Service Director (SSD), Social Service Worker (SSW) and Admission Coordinator (AC) the facility Administrator confirmed that he/she gave the directive via telephone on 5/26/12 to the NP to inform the family that Resident #1 had to be discharged from the facility because of the resident's "intense desire to leave, physical ability to leave the building and statements made by [Resident #1] that he/she would do it again, and that the facility could not ensure [Resident #1's] safety." The Administrator and DNS confirmed that no written notice of discharge was provided to Resident #1 or his/her family prior to discharge indicating when, why and where Resident #1 would be discharged and that Resident #1 was not provided with education of his/her rights regarding discharge and ability to challenge the discharge decision.</p>	F9999		
-------	---	-------	--	--