



VERMONT

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

April 24, 2013

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 **March 20, 2013**. 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".

Pamela M. Cota, RN
Licensing Chief

PC:jl



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

RECEIVED
Division of
APR 15 13
Licensing and
Protection
PRINTED: 04/04/2013
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 03/20/2013
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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 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 3/20/2013. The following regulatory deficiency was identified.	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 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 Precautions for resident #2 were removed 3/21/13. No other residents were impacted. Staff training conducted on Contact Precautions. Nurse Managers to randomly monitor staff interactions with residents on contact precautions and report findings to the QAPI committee monthly for 3 months. F441 POC accepted 4/11/13 MHiggins RN/pmc	3.26.13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4.11.13
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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.

pmc

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F 441	<p>Continued From page 1</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure prevention of the spread of infection during care of 1 resident in the sample. Findings include:</p> <p>During an observation of care for one resident (Resident #2), the LNA (Licensed Nursing Assistant) assisted with a one assist pivot transfer. The door is clearly marked as an isolation (contact precaution) room. The resident has off and on active diarrhea identified as "C-Diff", with the last positive culture being on 3/12/2013. In observation the LNA failed to gown and glove to perform the transfer. When questioned s/he stated that s/he would normally wear a gown when providing care but does not consider a transfer as direct care. When questioned s/he acknowledged the possibility of contaminating her/his hands and clothing during a resident transfer. In an interview at 12:50 PM the acting Unit Manager (also the Staff Development Nurse) stated that it is her/his expectation that staff would gown and glove to do a transfer for a resident with contact precautions. S/he stated that s/he had seen the transfer and intended to re-educate the LNA in question.</p>	F 441		
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