

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 9, 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 **May 14, 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,



Pamela M. Cota, RN
Licensing Chief

PC:jl



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

PRINTED: 05/30/2013
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 05/14/2013
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 333	Continued From page 1 Resident #1 had already received his/her own 8 AM medications which were administered by facility staff. Resident #1 was seen by the Advanced Practice Registered Nurse (APRN) a short time later and then was sent to Rutland Regional Medical Center Emergency Room. The medications the APRN stated in her note were of concern, and administered mistakenly to Resident #1 were Amidarone 200 mg, Mg Oxide 400 mg, Lisinopril 30 mg (in addition to his own 40 mg dose), Carvedilol 12.5 mg, and Digoxin 125 mcg. The APRN stated in the note that these medications put Resident #1 at risk for decompensation. There were other medications administered as well that were not considered to cause a risk. The resident was transferred to the Intensive Care Unit where s/he was monitored and treated for 24 hours and then returned to the facility on 5/2/2013 at 14:12 PM. The resident returned from the hospital with no apparent sequelae to the incident and remains in the facility. When interviewed s/he states that s/he is content here and working to go home. S/he states that s/he has no complaints about the care he has received.	F 333			