

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

January 31, 2013

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 **January 3, 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:ne

Enclosure



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

RECEIVED
Division of LICENSING AND PROTECTION
PRINTED: 01/18/2013
FORM APPROVED
JAN 24 13 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 _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED C 01/03/2013
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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 F 223 SS=D	<p>INITIAL COMMENTS</p> <p>An unannounced on-site complaint investigation was conducted on 1/3/13 by the Division of Licensing and Protection. The following are regulatory violations.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 1 resident identified (Resident #1) was free from verbal and mental abuse. The findings include:</p> <p>1. Per review of the facility medical record, Resident #1 was admitted to the facility on 4/6/10. S/he had diagnoses that included, unspecified intellectual disabilities, memory loss, cognitive communication deficit, Parkinson's disease and obesity.</p> <p>Per review of the facility's internal investigation dated 10/25/12, it was reported to Administration on 10/25/12 that two Nursing Students had overheard an interaction between a facility Licensed Nursing Assistant (LNA) and Resident #1 on 10/24/12. The investigation indicated that the two nursing students saw a facility LNA enter</p>	F 000 F 223	<p>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.</p> <p>F223 LNA was terminated.</p> <p>Center staff to complete abuse training</p> <p>Nurse Managers will audit staff interactions for appropriateness weekly x's 4 then monthly x's 3 months.</p> <p>Results of the audits will be reported to QAPI for further evaluation and recommendations.</p> <p>Oversight: the DNS will ensure completion.</p> <p><i>F223 POC accepted 1/25/13 MCMILLEN/RL/PMC</i></p>	2-1-13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Justin Thornton</i>	TITLE Administrator	(X6) DATE 1/23/13
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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 223	<p>Continued From page 1</p> <p>the room of Resident #1 to answer the residents call bell. The nursing students heard through the open door the LNA say to Resident #1 that she had just changed Resident #1 7.5 minutes ago and that the LNA was not going to change Resident #1 again. The facility investigation also indicated that the nursing students reported that approximately 5 minutes later, Resident #1 put his/her call bell on for assistance. The same LNA was observed by the students to re-enter the room and the students heard through the open door the LNA tell Resident #1, that the LNA was not going to change Resident #1's pad, and that if the resident did not stop pushing the call bell, the LNA would move him/her to the dining room to sit.</p> <p>Per review of the interview conducted on 10/25/12 with Resident #1, conducted by the Unit Manager (UM) on 10/25/12 at 1030 AM, Resident #1 confirmed that on 10/24/12, s/he placed his/her call bell on and when the LNA entered the room, the resident asked to be changed. Resident #1 indicated that the LNA told him/her that the LNA had just changed him/her and that the LNA was not going to change him/her again. Resident #1 indicated in the interview on 10/25/12 with the UM that s/he placed her light on again, the LNA entered the room and told him/her again that the LNA was not going to change him/her again and that s/he did not need to be using his/her call light as the LNA was busy.</p> <p>Per review of the progress notes dated 10/25/12, the Social Service (SS) Worker met with Resident #1 on 10/25/12 at 11:51 AM. The note indicates that Resident #1 indicated to SS that the evening before "the LNA was not nice to me". The note</p>	F 223		
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F 223	<p>Continued From page 2</p> <p>also indicates that Resident #1 told SS that Resident #1 felt "sad" about the incident with the LNA on 10/24/12.</p> <p>Per review of the Comprehensive Assessment (MDS) dated 9/24/12, Resident #1 is usually able to make needs known and has had no acute changes in mental status. The MDS indicates that Resident #1 needs extensive assistance (assistance that requires staff to assist resident) for toilet use and extensive assistance with personal hygiene and requires 1 staff member to help. Review of the MDS dated 9/24/12 also indicates that Resident#1 is always incontinent of urine and frequently incontinent of bowel. The MDS also indicates that Resident #1 is at risk for "developing pressure ulcers". The MDS and physician order indicate that Resident #1 takes a diuretic (water pill) daily. Per review of the Nursing Assessment dated 9/21/12, Resident #1 has very limited mobility, needs assistance, cannot bear own weight and has lower extremity impairment on one side.</p> <p>Per review of the facility policy titled "Abuse Prohibition", abuse is defined as, "any act that threatens a vulnerable adult's physical or emotional health or welfare". Per review of the internal investigation 10/25/12, the Administration indicated that based on the 2 separate witness statements and the recall of the incident by the resident, the facility terminated the LNA for behaving poorly and not responding appropriately to a resident's request.</p> <p>Per interview with the Administrator and Director of Nursing on 1/3/13, they confirmed that the statements made by the LNA to Resident #1 on</p>	F 223		
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F 223	Continued From page 3 10/24/12 were threatening the resident. Per interview with the Administrator and Director of Nursing on 1/3/13, they confirmed the LNA failed to provide care to a resident who requests it and to a resident who is incontinent of bladder and bowel, at risk for skin integrity issues and requires extensive physical assist for toileting needs.	F 223		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 1 resident identified (Resident #1) was free from neglect. The findings include: 1. Per review of the facility medical record, Resident #1 was admitted to the facility on 4/6/10. S/he had diagnoses that included, unspecified intellectual disabilities, memory loss, cognitive communication deficit, Parkinson's disease and obesity. Per review of the facility's internal investigation dated 10/25/12, it was reported to Administration on 10/25/12 that two Nursing Students had overheard an interaction between a facility	F 224	F224 Resident received care at approximately 4pm and again after the dinner meal. The resident was also wearing a protective incontinent product designed to keep skin dry. There was no skin issues noted as a result of the incident. The LNA was terminated. Center staff to complete abuse training. Nurse Managers will audit staff interactions for appropriateness weekly x's 4 then monthly x's 3 months.	2.1.13

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F 224	<p>Continued From page 4</p> <p>Licensed Nursing Assistant (LNA) and Resident #1 on 10/24/12. The investigation indicated that the two nursing students saw a facility LNA enter the room of Resident #1 to answer the residents call bell. The nursing students heard through the open door the LNA say to Resident #1 that she had just changed Resident #1 7.5 minutes ago and that the LNA was not going to change Resident #1 again. The facility investigation also indicated that the nursing students reported that approximately 5 minutes later, Resident #1 put his/her call bell on for assistance. The same LNA was observed by the students to re-enter the room and the students heard through the open door the LNA tell Resident #1, that the LNA was not going to change Resident #1's pad, and that if the resident did not stop pushing the call bell, the LNA would move him/her to the dining room to sit.</p> <p>Per review of the interview conducted on 10/25/12 with Resident #1, conducted by the Unit Manager (UM) on 10/25/12 at 1030 AM, Resident #1 confirmed that on 10/24/12, s/he placed his/her call bell on and when the LNA entered the room, the resident asked to be changed. Resident #1 indicated that the LNA told him/her that the LNA had just changed him/her and that the LNA was not going to change him/her again. Resident #1 indicated in the interview on 10/25/12 with the UM that s/he placed her light on again, the LNA entered the room and told him/her again that the LNA was not going to change him/her again and that s/he did not need to be using his/her call light as the LNA was busy.</p> <p>Per review of the progress notes dated 10/25/12, the Social Service (SS) Worker met with Resident</p>	F 224	<p>Results of the audits will be reported to QAPI for further evaluation and recommendations. Oversight: the DNS will ensure completion.</p> <p><i>F224 POC accepted 1/25/13 McLuhan RN / PMC</i></p>	

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F 224	<p>Continued From page 5</p> <p>#1 on 10/25/12 at 11:51 AM. The note indicates that Resident #1 indicated to SS that the evening before "the LNA was not nice to me". The note also indicates that Resident #1 told SS that Resident #1 felt "sad" about the incident with the LNA on 10/24/12.</p> <p>Per review of the Comprehensive Assessment (MDS) dated 9/24/12, Resident #1 is usually able to make needs known and has had no acute changes in mental status. The MDS indicates that Resident #1 needs extensive assistance (assistance that requires staff to assist resident) for toilet use and extensive assistance with personal hygiene and requires 1 staff member to help. Review of the MDS dated 9/24/12 also indicates that Resident#1 is always incontinent of urine and frequently incontinent of bowel. The MDS also indicates that Resident #1 is at risk for "developing pressure ulcers". The MDS and physician order indicate that Resident #1 takes a diuretic (water pill) daily. Per review of the Nursing Assessment dated 9/21/12, Resident #1 has very limited mobility, needs assistance, cannot bear own weight and has lower extremity impairment on one side.</p> <p>Per review of the facility policy titled "Abuse Prohibition", neglect is defined as, "the purposeful or reckless failure by a caregiver to provide adequate care (the goods and services needed to maintain reasonable health and safety) to a vulnerable adult."</p> <p>Per review of the internal investigation 10/25/12, the Administration indicated that based on the 2 separate witness statements and the recall of the incident by the resident, the facility terminated the</p>	F 224		
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F 224	Continued From page 6 LNA for behaving poorly and not responding appropriately to a resident's request. Per interview with the Administrator and Director of Nursing on 1/3/13, they confirmed the LNA failed to provide care to a resident who requests it and to a resident who is incontinent of bladder and bowel, at risk for skin integrity issues and requires extensive physical assist for toileting needs, because Resident #1 is unable to independently.	F 224		