

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 06/04/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Center Genesis Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9 Haywood Avenue Rutland, VT 05701	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interviews and record review, the facility failed to protect one resident (Resident #281) of 10 sampled residents from abuse. Findings include:</p> <p>Per review of the facility's OPS 300 Abuse Prohibition policy [last revised 10/24/22] states, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation of all residents .Verbal abuse is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients of their families .</p> <p>Per review of Resident #281's medical record s/he has diagnoses of acute respiratory failure with hypoxia, CHF [Congestive Heart Failure], and CKD [chronic kidney disease]. S/he had a BIMS [Brief Interview of Mental Status] of 13 out of 15 on 2/14/25 indicating shis/her cognitive function is intact. The MDS [Minimum Data Set] states that Resident #281 is independent with ADLs [Activities of Daily Living] and is continent of bowel and bladder.</p> <p>Per record review of the facility's internal investigation of the alleged abuse dated 2/18/25, Resident #281 reported verbal abuse that occurred on 2/17/25. Per the internal investigation, Resident #281 stated that LNA [Licensed Nursing Assistant] #1 entered his/her room after the resident had episode of incontinence and stated, If you haven't been incontinent at home why are you doing it here? .Do you poop your pants at home? Resident #281 and his/her roommate confirmed the same statements made by LNA#1 in interviews documented in the facility's internal investigation.</p> <p>Per the facility internal investigation, LNA#1 made the following statement: She stated that she did yell but she did tell the resident that it isn't going to help [him/her] here in rehab if [s/he] is doing this and [s/he] normally doesn't do it at home. An email statement from another LNA on 2/19/25 stated, I do not know what she said to [him/her] but I do know that when she came out of the room she was mad that she had to do a full bed on [him/her] because [s/he] was incontinent of stool. She stated that s/he [Resident #1] just Laid there and [expletive] [his/herself] .She was very unhappy to have to clean this resident and made it very clear to me and another LNA.</p> <p>Per record review of the facility's internal investigation, the verbal abuse was confirmed by the facility.</p> <p>Per interview with the Administrator on 6/4/25 at 12:07 PM, the Administrator confirmed that the verbal abuse occurred and that Resident #281 was not free from abuse.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 475012	If continuation sheet Page 1 of 1