STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475012	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Center Genesis Healthcare	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to implement interventions to ensure residents were free of accidents for 1 of 3 residents (Resident #1). As a result, a resident suffered a fall which required hospitalization related to a fractured hip and pain management. Findings include: Per record review, Resident #1 has diagnoses that include irradiation of the pelvis, epilepsy, presence of an artificial eye, and normal pressure hydrocephalus (a neurologic condition characterized by an abnormal accumulation of cerebrospinal fluid in the brain). Per review of the Minimum Data Set (MDS-a standardized tool used to evaluate residents' needs and improve care planning) dated 5/30/25, in the section titled Functional Limitation in Range of Motion, Resident #1 has an impairment on one side of the upper body and an impairment on both sides of the lower body. Per review of Resident #1's care plan, a focus reveals that Resident requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, toileting related to chronic disease/condition: limited mobility, legally blind the corresponding intervention reads to provide the resident with 2 assist for Activities of daily living (ADL) care, with an initiation date of 5/5/23.Per review of a facility incident report dated 7/27/25, Resident #1 had a witnessed fall from the bed while receiving care from a Licensed Nursing Assistant (LNA) on 7/26/25. Per review of the 5-day summary report submitted to the State Agency, dated 8/1/25, Resident #1 was non-weight-bearing, at his/her baseline, and required complete care. After the fall, s/he reported pain in his/her right hip, back, and the back of his/her head. Resident #1 was transported to the hospital and was admitted for a left femoral neck (hip) and inferior and superior (Pelvic) pubic rami fracture. A Discharge Planning Form dated 7/27 from the local hospital reveals that Resident #1 was admitted to the hospital for management of severe hip pain. Per interview on 9/9/2025 at 2:38 PM with a Licensed Nursing Assistant (LNA) who was providing care for Resident #1 when the incident occurred, it was revealed that the LNA was providing evening care to the resident without assistance. The resident required a complete change of bed linen. When the LNA attempted to tuck in the sheets, he rolled the Resident #1 to the side of the bed; without assistance, s/he fell onto the floor.Per interview with the Unit Manager (UM) on 9/9/2025 at approximately 2:45 PM, she stated Resident #1 needs 2 people to assist with ADL care as mobility is limited. She states that the care plan includes this intervention, and the expectation is that the staff will follow it for safety. She states the resident would not have fallen had the interventions been followed.

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