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	04/08/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to implement safe mechanical lift procedures to prevent an avoidable accident for 1 of 5 sampled residents (Resident #1). The facility did not ensure that staff operating the mechanical lift were competent in the task per the facility policy. During transfer, Resident #1 sustained multiple skin tears and fractures to their body, including a fracture of the right femur (thigh bone) and a fracture to the left humerus (upper arm bone). This is a repeat violation previously cited in a partial survey dated 9/9/25. Findings include:Per record review, Resident #1 was admitted to the facility on [DATE] and has diagnosis that include rheumatoid arthritis (autoimmune disease that targets the joint lining resulting in pain, stiffness, and swelling), degenerative joint disease (commonly known as osteoarthritis which is the protective cartilage that cushions the ends of the bones wears down over time), and osteoporosis (bone disease where decreased bone mass and density make bones weak, brittle, and prone to fractures). On 4/2/26 at approximately 11:00 AM, the record notes the resident fell during a transfer from a Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility in a sling) while being assisted from their bed to their wheelchair. Resident #1 was care planned for transfers with two staff members using a Hoyer lift due to mobility issues. The facility's initial summary report describes an incident on 4/2/26 in which Resident #1, being transferred from bed to a chair using a Hoyer lift, leaned to the left, partially slipping out of the moving device. The transfer was aborted, and the resident was returned to bed and assessed for injury by a nurse. The report continues to state that the assessment revealed left shoulder pain with no loss of range of motion or swelling, and two skin tears. The skin tear measurements are right anterior elbow total flap loss area of 31.96 cm (no tissue flap attached and there is an open wound bed), total flap loss of the right inner forearm having an area of 24.68 cm, and right leg partial flap loss having an area of 3.34 cm (tissue loss extensive enough that only part of the flap can be repositioned over the wound bed). The resident remained at the facility, and the physician ordered an X-ray of the resident's left shoulder after assessing the resident in their room. At 1:45 PM during another transfer from the chair to the bed, the resident reported right hip pain along with noted swelling, and the physician was contacted again. It was determined at that time for the resident to be transferred to the hospital for further assessment.Review of the Emergency Department note from 4/2/26 at 10:22 PM after the incident noted a diagnosis of a fracture of the right femur (thigh bone), and a fracture to the left humerus (upper arm bone), and having skin tears (traumatic, often partial-thickness wounds caused by friction, shear, or blunt force that separate the skin layers) to the resident's right arm and right lower leg plus bruising of right foot.Per interview with Licensed Nursing Assistant #1 (LNA) on 4/7/26 at 2:00 PM, she confirmed that she was transferring Resident #1 from their bed with LNA #2, and that the Resident started moving their shoulders and was slipping from the Hoyer sling. She continued to describe the lift repeatedly hitting the mechanics of the resident's bed, and it was chaotic trying to return the lift back under the bed. She stated, just didn't look right, and the resident was in a straight line instead of appearing 'scooped' in the transfer sling, and the sling was moving back and forth with LNA #2 (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	attempting to help guide the resident back to the bed from the other side. LNA #1 stated that once the resident was above the bed, they slipped out of the sling towards the footboard. LNA #1 was asked what the resident's height above the bed was when they slipped out of the sling, and the LNA gestured with her hands to indicate approximately 12 inches. LNA #1 continued stating the resident sustained skin tears to her right side due to the rubbing on the material of the Hoyer sling, and having skin like paper. Per interview with the Unit Manager (UM) on 4/7/26 at 2:30 PM, she stated that Resident #1 has contractures (permanent, rigid tightening of muscles, tendons, skin, or tissues around a joint, restricting motion and causing deformity) and isn't flexible in movements. The UM reports that the staff transferring the resident stated the resident was stiff during the attempted move. UM was asked the height of the resident when they slipped out of the Hoyer sling, and she gestured with her hands to show approximately twelve inches.Per interview with the Physical Therapist (PT) on 4/8/26 at 8:15 AM, she confirmed the resident's size was appropriate for use of the Hoyer lift, and the resident's contractures wouldn't have impacted the transfer. PT confirmed that Resident #1 had been transferred using the Hoyer lift since admission on [DATE], and no other incidents of slippage from the sling were reported. She confirmed a meeting with Resident #1 after the transfer incident, and the resident complained of discomfort with their left shoulder. Per interview with the Medical Director (MD) on 4/8/26 at 9:25 AM, he confirmed he was aware of the incident involving Resident #1 and that he had evaluated them after the incident. He revealed he ordered an X-ray (medical imaging test) of the resident's left shoulder due to discomfort and didn't believe it was urgent, so they could wait for the X-ray staff to arrive at the facility. He confirmed that, upon notification of the resident's right hip pain, the resident needed to be seen sooner for imaging and was transferred to the hospital. When asked about his understanding of the incident, he stated that two LNAs were transferring the resident from bed to a wheelchair when the resident turned to the left and began slipping. He continued, stating LNA #2 was holding the resident and guiding the resident over the bed. The MD revealed that LNA #2 stated the resident was 12 inches from the bed when they slipped feet-first onto the bed. He confirmed that the resident's injuries could have resulted from a fall of 12 inches, based on the medical diagnosis and treatments they received. He confirmed the skin tears were most likely due to shearing caused by the skin in contact with the Hoyer sling and the resident sliding.Per interview with LNA #2 on 4/8/26 at 10:00 AM, she confirmed Resident #1 was being transferred using the Hoyer Lift with LNA #1, and everything looked fine and normal, but then the resident slid to their side during the transfer. LNA #2 reports trying to save the resident from falling on the floor, and was guiding them over the bed, but when they slid out of the sling, they were twelve inches above the bed. She confirmed the resident sustained skin tears on their right side and was complaining of discomfort in their left shoulder.Per interview with a Licensed Practical Nurse (LPN) on 4/8/26 at 10:30 AM, she stated she was a second set of eyes after the incident during the assessment of Resident #1. She revealed the resident complained of shoulder pain and had skin tears from their skin rubbing against the Hoyer sling.The following statements collected by facility leadership with staff revealed that LNA #2 reported Resident #1 hit the arm of the Hoyer lift when attempting to move them back over the bed, and then they slid out of the sling, and in a later summary with LNA #2, she reports Resident #1 bumped the piston with [his/her] right hip twice. The summary also reveals that when the resident slid out of the sling, they landed on the bottom third of the bed. Per interview with the Director of Nursing (DON) on 4/8/26 at 11:30 AM, the DON was asked about the skill competencies for LNA #1 and confirmed that her competencies in the proper use of the Hoyer lift were not demonstrated before the incident. See 726 for more information.Review of the facility's Accidents/Incidents policy, last revision 3/1/24, includes a definition of an accident as any unexpected or incident which may result in injury. The facility's Safe Resident Handling/Transfer Equipment policy, last revised 3/1/24, states, Staff will complete training and demonstrate competency in the use of safe resident handling equipment. Reference:https://skil-care.com/product/geri-sleeves/https://jamanetwork.com/journals/[NAME]/fullarticle/2790

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to ensure that 1 of 3 sampled Licensed Nursing Assistants possessed the specific competencies necessary to meet residents' needs, as identified through resident assessments and the plan of care. The facility did not ensure that staff operating the mechanical lift were competent in the task per the facility policy, which led to a resident sustaining multiple fractures and skin tears (Resident #1). This has the potential to affect all residents of the facility. Findings include:Based on the interview and record review, the facility failed to ensure that 1 of 3 sampled Licensed Nursing Assistants possessed the specific competencies necessary to meet residents' needs, as identified through resident assessments and the plan of care. The facility did not ensure that staff operating the mechanical lift were competent in the task per the facility policy, which led to a resident sustaining multiple fractures and skin tears (Resident #1). This has the potential to affect all residents of the facility. Findings include:Review of three Licensed Nursing Assistant (LNA) education files showed that LNA #1, contracted staff from Clipboard Health, lacked evidence of assessment for clinical competencies, including Safe Resident Handling, before being assigned to resident care. The packet titled Genesis Mandatory Training Participation Guide indicated that educators would show, explain, and demonstrate resident handling competencies.Per review of the facility-reported incident, on [DATE] at approximately 11:00 AM, LNA #1 was assisting Resident #1 with being transferred, in which the resident fell during the transfer from a Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility in a sling) while being assisted from their bed to their wheelchair. Resident #1 was care planned for transfers with two staff members using a Hoyer lift due to mobility issues. Resident #1 was initially assessed by their physician and an X-ray was ordered due to left shoulder pain but was transferred to the hospital for evaluation later in the day due to additional reports of pain. Review of the Emergency Department Note dated [DATE] at 10:22 PM after the incident noted a diagnosis of a fracture of the right femur (thigh bone), and a fracture to the left humerus (upper arm bone), and having skin tears (traumatic, often partial-thickness wounds caused by friction, shear, or blunt force that separate the skin layers) to the resident's right arm and right lower leg plus bruising of right foot. See F689 for more informationPer an interview with the Director of Nursing (DON) on [DATE] at 1:49 PM, he stated that Clipboard Health verifies its employees' competencies, and the employee's signature on the back of the Genesis Mandatory Training Participant Guide packet indicated the person was qualified. Documentation was requested regarding the competency for Safe Resident Handling, as indicated in the packet. The DON stated the packet wasn't the facility's document but was Clipboard Health's. The DON was asked about the Genesis heading on the packet and denied that the packet was from the facility. Per interview with Clinical Support at Clipboard Health, the contracted company, on [DATE] at 2:08 PM, the Clinical Support representative stated the company doesn't review competencies or have specific training provided to employees. The requirements are for employees to provide a copy of their professional license, proof of basic life support (BLS) or cardiopulmonary resuscitation (CPR) certification, a driver's license or state identification card, Tuberculosis (TB) testing, and background checks. The Clinical Support person confirmed that the Genesis Mandatory Training Participation Guide is not part of their requirements or their document.Per interview with the Administrator and DON on [DATE] at 2:50 PM, they confirmed there is no documentation of competencies for the contracted employees. When asked how many employees from this service are used at the facility, the Administrator stated that it varies but thought it was 3 to 4 per day.A review of the facility's list of contracted Clipboard employees over the last 12 months revealed 59 employees had been scheduled at the facility. A review of the shifts worked by LNA #1 indicated that LNA #1 had worked 11 shifts since starting at the facility without evidence of patient care competencies. Per interview (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	with the DON on [DATE] at 3:26 PM, the DON confirmed that all staff listed received the same informational packet as LNA #1 which he believed to be an assessment of competency by the contracted agency, not the facility, that LNA #1 worked 11 shifts without the facility verifying LNA #1's competency, and that the facility failed to verify the competencies of any contracted employees from this service before allowing them to work with residents.