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	06/03/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and policy review, the facility failed to ensure that expired medications were removed from 1 of 2 medication storage rooms observed and 1 of 4 medication carts observed. The facility also failed to ensure medication carts remained locked when unattended during an observation. This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 6/4/26. Findings include: 1. Per observation on 6/2/2026 at approximately 9:24 AM, the medication cart on Beach unit was reviewed and Mirtazapine 15 milligrams (mg) for Resident #130 was expired on 5/23/26. The nurse confirmed that the medication was expired. Per observation on 6/2/2026 at approximately 11:22 AM, the Beach unit medication room was reviewed and 2 over the counter bottles of Bisacodyl 5mg expired on 4/2026. Per interview on 6/2/2026 at approximately 11:35 AM, the nurses on the unit confirmed that the 2 bottles of Bisacodyl 5mg were expired. Per the facility's Medication Storage policy revision date 1/26 page 3 of 3 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal . 2. On 6/3/26 at 8:48 AM, an observation was conducted at the facility's Cherrytree, a memory care unit. An unlocked medication cart was observed in the common area, where several residents were present. No facility staff was observed at or near the medication cart. During an interview on 6/3/26 at 9:15 AM, the Registered Nurse (RN) assigned to the medication cart confirmed that it should have remained locked at all times when unattended. The RN confirmed she failed to lock the medication cart and stated she made a mistake. Review of the facility's policy titled Storage of Medication, last revised in 1/2026, indicated that medication rooms, cabinets, and medication supplies should remain locked when not in use or attended to by persons with authorized access.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview the facility failed to provide privacy during care for 1 of 32 sampled residents (Resident #93). Findings includePer observation on 6/1/26 at 12:16 PM on the Dogwood unit, a Licensed Practical Nurse (LPN) was preparing and gathering supplies from the wound care cart parked outside of Resident #93's room. Resident #93 was sitting on the side of the bed eating lunch. The LPN rolled up Resident #93's right shirt sleeve and began to assess the area where a bandage would be applied. Resident #93 was trying to continue eating their salad while LPN was documenting and labeling the dressing. When the LPN was ready to apply the dressing, he asked the resident to put their salad down. This interaction was observed from the hallway as there was no privacy curtain pulled and the door was open. Five people were observed walking by the room. Per interview at approximately 12:25 PM on 6/1/26, the LPN confirmed the door and privacy curtain were open and that they should have been closed to provide Resident #93 with privacy during wound care.Per interview with Unit Manager of the Dogwood unit on 6/2/26 at approximately 10:40 AM, the Unit Manager confirmed that it is never appropriate for a dressing to be applied or removed during mealtime, and that privacy should always be provided for wound care

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure two of 32 sampled residents (Resident #63 and Resident #11) were care planned for concerns related to hearing and communication and positioning. Findings include: 1. Per observation on 6/1/26 at 11:36 AM, Resident #11 was observed sitting in their wheelchair, leaning over the arm rest on the right. Resident # 11 was seated in a high back wheelchair with a head rest, leg rests and a cushioned foot board between the leg rest. They also had two cushioned wedge devices at their hips on the right-hand side. Per interview with a Licensed Practical Nurse (LPN) on 6/1/26 at 12:07 PM, they explained that Resident #11 leans to the right frequently and requires position changes as needed. LPN #1 stated that Resident #11 recently received a new high back wheelchair to assist with their positioning. Per record review, Resident #11 was not care planned for positioning or the use of additional positioning devices while in the wheelchair. Per interview with Unit Manager Registered Nurse on 6/2/26 at approximately 10:00AM, they confirmed that Resident #11 was not care planned for positioning devices, or positioning while they are in their wheelchair and they should be. 2. An interview was conducted with Resident #63 on 6/1/26 at 12:13 PM. Resident #63 stated one of his/her hearing aids broke and was waiting on a replacement. An interview was conducted with the Unit Manager on 6/2/26 at 11:14 AM. The Unit Manager stated the resident's hearing aids were currently being replaced by ENT [otolaryngology]. Per record review of Resident #63's care plan, there was no documentation concerning the resident's hearing, needs for communication, or use of hearing aids. Per review of the facility's OPS416 Person-Centered Care Plan policy [last revised 10/24/22] states, The care plan will be prepared by the interdisciplinary team.The interdisciplinary team, in conjunction with the patient and/or patient representative, as appropriate, will establish the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.Purpose: To attain or maintain the patient's highest practicable physical, mental and psychosocial well-being. An interview was conducted with the DON [Director of Nursing] on 6/2/26 at 12:49 PM. The DON presented a care plan that showed Resident #63 was care planned for hearing. Per record review, the area of concern for hearing and interventions were added the same day as the interview, 6/2/26. The DON confirmed that hearing, communication needs, and hearing aid interventions were not added to Resident #63's care plan until 6/2/26.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise and implement a person-centered care plan for 1 of 32 sampled residents (Resident #48). The care plan was not revised and implemented to address Resident 48's escalating pattern of aggressive verbal and physical behavior. Findings include: Per record review, Resident #48 has diagnoses that include anxiety disorder, major depressive disorder, and dementia. Per an MDS (Minimum Data Set, a resident assessment tool) dated 12/3/25, Resident #48 had a BIMS (Brief Interview for Mental Status) score of 15, indicating fully intact cognition (the ability to perceive, learn, remember, reason, and problem-solve). An MDS dated [DATE] repeated the BIMS score of 15. Per record review, a social service note dated 2/12/26 states that Resident #48 was made aware by the Social Worker that resident makes comments to others and they feel [sh/e] is putting them down, or telling them what they can or cannot do, a concern brought forward by more than one person. In response, Resident #48 swore at the Social Worker. An assessment of Resident #48 dated 3/3/26 and noted as an interdisciplinary evaluation participated in by RN #1, DON (Director of Nursing), NP (Nurse Practitioner), and MD (Medical Doctor) states, Since the last evaluation there has been no change in behavior symptoms. Yelling and accusatory toward others at times. A social service note dated 4/7/26 states that the social worker was walking down the hall and heard Resident #48 swearing and yelling at others. The social worker notes, Resident proceed to call this writer names and said I was the biggest F- B- in this building. A social service note dated 4/30/26 states, Resident expressed that [s/he] was upset that Resident #56 had [her/his] coloring paper and when [s/he] asked for it back, s/he did not give it to [her/him] so [s/he] swatted [her/him]. A facility investigation report dated 5/4/26 states that Resident #48 slapped Resident #56 on their back. This investigation report also states that care plans were updated. A nurses note dated 5/23/26 states that Resident #48 entered the dining room, calling Resident #56 a fat [expletive]. When the nurse attempted to redirect Resident #48 out of the area, Resident #48 told the nurse to f-off. A nurses note dated 5/26/26 notes that Resident #48 stated to Resident #56, Well got anything to say to me now. I dare you. I'll knock you. S/he told the other resident that s/he had no problem fighting them, and Resident #48 was calling other residents names and using profanity as s/he left the room. The nurse notes that she was concerned the situation would escalate. During an interview with the Social Worker on 6/2/26, she confirmed that Resident #48 gets jealous, gets possessive of her/his things or where she/he is sitting and has acted out bother verbally and physically to other residents, including Resident #56. Resident #48 has a care plan focus dated 11/13/23 related to the potential verbal and physical behaviors. The most recent revision to this care plan is dated 5/6/25 with no newer interventions to address Resident #48's continuing pattern of escalating behaviors. Per interview with the Director of Nursing on 6/3/26 at 8:10 AM, he confirmed there had been recent verbal and physical behaviors by Resident #48 and he could not provide evidence of new care plan interventions to address them.