VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

June 23, 2026

Ms. Amy Russell, Administrator
Mountain View Center Genesis Healthcare
9 Haywood Avenue
Rutland, VT 05701

Provider ID #: 475012

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **June 3, 2026.** 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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475012	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Center Genesis Healthcare	**9 Haywood Avenue , Rutland, Vermont, 05701**

(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
E0000	Initial Comments An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 6/1/26 to 6/3/26 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified no regulatory violations.	E0000	The filing of this plan of correction for Mountain View Center does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	07.10.26
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of one complaint #3030039 from 6/1/26 through 6/3/26 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. No deficiencies were cited as a result of the complaint investigation. Deficiencies were cited as a result of the recertification survey.	F0000	Date of Compliance: July 10th, 2026 F0761: 1. There were no negative impacts on residents. Outdated items were destroyed and medication carts were secured. 2. An initial audit was conducted and no other drugs/biologicals identified. Medication carts noted to be locked. 3. Nursing staff re-education completed regarding the labeling and storage of drugs and biologicals. 4. DON/designee will conduct weekly audits x4 and then monthly x3 on all 4 wings to ensure medication carts are secured and drugs/biologicals are not expired. Also, medication rooms will be checked for outdated drugs/biologicals. Compliance and results to be reviewed at QAPI meeting for further review and recommendations. **Tag F0761 POC accepted on 6/23/26 by T. Dougherty/S. Stem**	
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F0761		

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=0761 SS = E	Continued from page 1 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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."	F0761		

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=0761 3S = E	Continued from page 2 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."	F0761		
=0583 3S = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to provide privacy during care for 1 of 32 sampled residents (Resident #93). Findings include Per observation on 6/1/26 at 12:16 PM on the	F0583	F0583 1. There were no negative impacts on resident #93. 2. An audit was conducted and no other residents with wounds were affected. 3. Nursing staff re-education completed regarding personal privacy and confidentiality. 4. DON or designee will conduct weekly audits x4 and then monthly x3 to ensure that the facility is respecting the residents right to personal privacy. Compliance and results to be reviewed at QAPI for further review and recommendations. **Tag F0583 POC accepted on 6/23/26 by T. Dougherty/S. Stem**	

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F0583 SS = D	Continued from page 3 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	F0583	F0656 1.There were no negative impacts on residents #63 and #11. Care plans for residents #63 and #11 have been updated. 2. Residents who require hearing and communication devices as well as positioning have the potential to be affected by this alleged deficient practice. 3. Nursing staff has been re-educated on the development and implementation of a comprehensive care plan. 4. The DON/Designee will audit care plans to ensure hearing and communication devices as well as position devices are care planned as necessary weekly x4, monthly x3. Results till reviewed at QAPI for further recommendations. **Tag F0656 POC accepted on 6/23/26 by T. Dougherty/S. Stem**	
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F0656		

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F0656 SS = D	Continued from page 4 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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	F0656		

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=0656 SS = D	Continued from page 5 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.	F0656		
=0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F0657	F0657 1. There were no negative impacts on resident #48. Care plan for resident #48 was revised and updated as needed.	

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F0657 SS = D	Continued from page 6 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: 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 3/3/26 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	F0657	F0657- Continued. 2. An audit was conducted and no other residents were affected. 3. Staff education completed regarding timely revision of care plans for those residents demonstrating an escalating pattern of aggressive verbal and physical behavior. 4. DON or designee will conduct weekly audits x4, monthly x3 to ensure that those residents demonstrating an escalating pattern of aggressive and verbal and physical behavior have timely revisions of their care plans. Results of audits will be reviewed at QAPI for further recommendations. **Tag F0657 POC accepted on 6/23/26 by T. Dougherty/S. Stem**	

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F0657 SS = D	Continued from page 7 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	F0657		

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=0657 3S = D	Continued from page 8 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.	F0657		