STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLAGES OF ORLEANS HEALTH AND REHAB CENTER	14012 ROUTE 31 ALBION, NY 14411

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 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review conducted during the Standard Survey completed on 9/14/20, the facility did not ensure that residents receive proper treatment and assistive devices to maintain hearing abilities for one (Resident #65) of one resident reviewed. Specifically, resident #65's hearing was assessed as highly impaired and the resident did not have their hearing aide available to them. Additionally, staff did not know the status of the resident's hearing aide (missing/broken or out for repair). The finding is: 1. Resident #65 with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - a resident assessment tool) documented the resident was severely cognitively impaired, sometimes understood and sometimes understands. Section B of the MDS documented resident #65's hearing ability was highly impaired and that they do not wear a hearing aide. The Comprehensive Care Plan (CCP) dated 5/1/18 documented resident #65 had a communication problem related to hearing deficit with interventions including to allow adequate time to respond, repeat if necessary, request clarification from resident to ensure understanding and use alternative communication tools as needed. The CCP did not document the resident required the use of a hearing aide and/or when to use it. The Pocket Care Plan (guide used by staff to provide care) dated 9/14/20 had no documented evidence the resident was HOH or required the use of hearing aides. Review or the Medication Administration Record [REDACTED]. During an observation on 9/9/20 at 2:30 PM resident #65 was sitting in the common area of the unit in their wheelchair (w/c) and there were no hearing aides in the resident's ears. During an observation on 9/10/20 at 7:50 AM Resident #65 was out of bed (OOB) sitting in a w/c outside of their room, there were no hearing aides in the resident's ears. Licensed Practical Nurse (LPN #1) placed a breakfast tray on the over bed table in front of the resident and in a very loud tone told the resident (directly in their right ear), what was on the tray. During an interview on 9/10/20 at 8:05 AM the surveyor attempted to interview resident #65. Resident #65 stated that she was unable to hear. During an interview on 9/10/20 at 12:55 PM, LPN #1 stated the resident wears a left hearing aide. The hearing aide broke about a month and a half ago and it's out for repair. The hearing aide is supposed to be stored in the medication cart in the case, but it was not there. Before COVID-19 the resident would have visitors come in and they would request the hearing aide to be put in Resident #65's ear. The resident was known to take out their hearing aide, put it in their pocket or lose it. During an interview on 9/10/20 at 1:13 PM, the Unit Clerk on Orchard View stated she was unsure how resident hearing aides are tracked or if it was out for repair. During an interview on 9/10/20 at 1:29 PM, the Social Worker (SW) stated she does not track resident hearing aides or if it is out for repair. The SW did not know if Resident #65 had a hearing aide. During an interview on 9/10/20 at 2:46 PM the LPN #2 Unit Manager (UM) stated resident #65's hearing aide was broken during the COVID-19 outbreak and was unsure if it went out for repair or if the resident's son took it out for repair. Review of the Progress notes dated 7/1/20 to present 9/10/20 revealed there was no documented evidence that the resident's hearing aid was lost broken or out for repair. During a telephone interview on 9/11/20 at 11:34 AM the resident's family member revealed Resident #65 has a hearing aid but the resident tends to take it out, misplaces it, and can even take it apart. The family members stated that the facility will put the hearing aide in for MD and family visits, then take it back. The family member stated they were unaware the hearing aide was missing and/or broken and did not take it for repair. The family member stated, Usually they are pretty good about letting me know things, but they did not tell me if it was missing or broken. During an interview on 9/11/20 at 1:35 PM, the Director of Nursing (DON) stated if the resident can't care for the hearing aide it is documented on the TAR by the nurses when it is put in and taken out. The DON stated that she was unaware the resident's hearing aide was missing or broken. A facility policy and procedure was requested regarding care of resident hearing aides on 9/14/20, the facility did not provide a policy and procedure. 415.12(3)(b)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review conducted during the Standard Survey completed on 9/14/20, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility did not ensure the proper care of a PICC line (peripherally inserted central catheter- a catheter that is inserted through a vein and advanced until the tip enters the central venous system) for one (Resident #172) of one resident reviewed for infections. Specifically, the Registered Nurse (RN) Assistant Director of Nursing (ADON) Infection Preventionist (IP) did not perform proper hand hygiene during routine care of a PICC and did not replace the primary IV (intravenous) tubing after the tubing fell on the floor. Additionally, the facility did not conduct or complete a Legionella risk assessment of the facility to identify where Legionella and other opportunistic pathogens could grow and spread in the facility's water system and the facility did not have a water management plan in place for the facility to reduce the risk of growth and spread of Legionella and other opportunistic pathogens. This affected five (Autumn View North, Autumn View South, Canal View, Garden View and Orchard View) of five resident units and the Administrative Wing. The findings are: 1. Resident #172 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - a resident assessment tool) dated 9/3/20 documented the resident was understood, understands, cognitively intact and received IV medications and antibiotic medications for seven days. The facility policy and procedure (P&P) titled Hand Hygiene with a revision date 5/10/20 documented handwashing is regarded as the single most important means of preventing the spread of infection. All personnel shall wash their hands to prevent the spread of infection and disease. Appropriate 20 second handwashing must be performed after and in some cases before the following conditions: between contact with each resident; before performing dressing care; after having contact with a resident in isolation; after handling used dressings, urinals, bedpans, catheters, tissues, linens, etc.; before and after manipulation of IV sites or tubing administration. When performing tasks or duties requiring the use of gloves, the employee will wash their hands following the facility procedure; don (apply) clean gloves; complete specified task; dispose of any soiled items appropriately, including the gloves; wash hands; handwashing will be performed and gloves reapplied for each task. The facility P&P titled PICC Lines with a revision date of November 2017 documented prior to accessing PICCs for any reason, nurses must perform appropriate hand hygiene procedures. Review of guidance from the CDC (Centers for Disease Control) dated 3/2020 documented hand washing should be completed for 20 seconds when using soap and water and alcohol based hand rub (ABHR). The facility Order Summary Report dated 9/14/20 documented the following orders: - Sodium Chloride (NS) Flush Solution use 10 cc (cubic centimeter) intravenously every shift for patency related to infection of amputation stump, RLE. - PICC LUE (left upper extremity). Change dressing every Friday related to infection of amputation stump, RLE. During an observation on 9/11/20 at 7:48 AM the ADON Infection Control Preventionist entered resident #172's room, gathered the supplies to flush the resident's PICC, and without performing hand hygiene applied gloves, and flushed the PICC. During an interview on 9/11/20 at 7:50 AM, the ADON IP stated hand hygiene was to be completed before applying gloves and after removing gloves to stop the spread of infection. The ADON IP stated, I forgot to wash my hands, it was just a slip. During observations on 9/11/20 at 1:35 PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) revealed the ADON IP entered the room of a resident on precautions (measures taken to prevent the spread of infection), put on an isolation gown, without wearing gloves placed a sandwich on the over the bed table, removed the gown, and exited the precaution room without washing her hands. The ADON then retrieved from the medication cart, entered Resident #172's room, and placed the ABHR on the bedside stand. The ADON entered the resident's bathroom, washed her hands for 10 seconds and applied clean gloves. While wearing the clean gloves she re-entered the residents living space, moved a urinal containing 200 cc of a dark amber liquid from the over the bed table and placed it on the window ledge, wiped the over the bed table with germicidal wipes, and removed the residents gown to expose the PICC insertion site. The ADON removed the gloves, did not wash her hands and applied clean gloves. While wearing the clean gloves she opened a package of sterile gloves and applied a surgical facemask to resident. The ADON removed the gloves and applied the sterile gloves without washing her hands. While wearing the sterile gloves she removed the resident's PICC line dressing, removed her gloves and completed hand hygiene with ABHR for 5-7 seconds. The ADON applied clean gloves, cleansed the PICC insertion site, removed gloves, and completed hand hygiene with an ABHR for 7 seconds. The ADON applied clean gloves, completed the dressing change and completed hand hygiene with an ABHR for 5-7 seconds. During continued observation the ADON applied clean gloves and flushed the PICC line. While the ADON was flushing the PICC line, the IV medication tubing fell on to the floor. Twelve inches of tubing including the connection lock was directly on the floor. The ADON removed the tubing from the floor, wiped the connection lock with an alcohol pad and began to connect the IV medication administration tubing to the PICC. When asked the ADON IP stated she was about to connect the tubing to the PICC line, the State Surveyor stopped the procedure. During an interview on 9/11/20 at 2:06 PM, the ADON IP stated hand hygiene when using soap and water or ABHR should be completed for at least 20 seconds. In addition, he stated that not using the ABHR long enough and dropping the IV line on the floor without replacing the the tubing could potentially contaminate the resident. During an interview on 9/14/20 at 10:14 AM, the Administrator stated the standard protocol for infection control was to perform hand hygiene with soap and water or ABHR for at least 20 seconds. In addition, the IV line should have been discarded and replaced after it fell on the ground. 2a. Review of the undated Legionella Risk Assessment revealed: - There was no evidence this assessment was reviewed at least annually. The document was not dated. - There was no evidence that the assessment was unique to this facility. The assessment had Facility Name written on the top of its one and only page. - The assessment consisted of eight, yes or no questions. - An incomplete statement on the assessment, Based on the above assessment, The (space left blank, not answered by facility) should develop a water management plan for the building's hot and cold-water distribution system and was not completed annually. - The Legionella Risk Assessment document did not Identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. b. Review of the undated Legionella Water Management Program Team document revealed: - There was no evidence this assessment was reviewed at least annually. The document was not dated. - There was no evidence that the assessment was unique to this facility. The assessment had Facility Name written on the top of its one and only page. - The portion of this document labeled Team Members did not specify who was assigned to each role for the following: Administrator, Director of Maintenance, Director of Housekeeping and Laundry, Director of Nursing. Infection Control Coordinator - The Legionella Water Management Program Team document did not identify a building specific water management plan. Did not describe the water distribution system. Did not describe control measures and actions to be taken if control measures not met. c. Review of the undated Legionella Control Measures document revealed: - There was no evidence this assessment was reviewed at least annually. The document was not dated. - There was no evidence that the assessment was unique to this facility. The assessment had Facility Name written on the top of its one and only page. During an interview on 9/10/20 at 1:05 PM, the Administrator stated, The Legionella Risk Assessment, Legionella Water Management Program Team and Legionella Control Measures were documents provided by the vender that put together the facility's water management plan. The Administrator did not know the name of the vendor that put together the facility's water management plan. The Administrator further stated, the facility never conducted a Legionella risk assessment because the facility never had Legionella, so it did not need to conduct a Legionella risk assessment. The Administrator had no other documentation to submit for the Legionella risk assessment or water management plan. The facility did not have an A-Wing or a B-Wing as identified on the Legionella Control Measures document. 415.1(a)(1-3)(b)(2,4)