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 _____	08/13/2020

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 0600
 	
Level of harm - Minimal harm or potential for actual harm
 	
Residents Affected - Few
	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.
	NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
	Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #NY 552) completed on 8/11/20, the facility did not ensure the resident's right to be free from abuse for two (Residents #1, 2) of three residents reviewed for sexual abuse. Specifically, Residents #1 and 2 were observed engaged in sexual activity and per the physician lacked the cognitive ability to consent. Additionally, per the facility policy Resident #1 and #2 were not evaluated by the facility for capacity to consent in sexual activity after the engaged sexual activity occurred. The finding is: The facility policy and procedure (P&P) titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property revised date 2/2015 documented the facility prohibits abuse, neglect and mistreatment of [REDACTED]. Inappropriate physical contact includes, but is not limited to, striking, pinching, kicking, shoving, bumping, and or sexual molestation. The facility P&P titled Sexual encounter amongst Residents revised date 1/1/2015 documented in the event residents are found to be performing sexual activity - residents will have their cognitive function evaluated and identify whether they have capacity to accept or deny sexual activity. 1. Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - a resident assessment tool) dated 7/17/20 documented Resident #1 usually understands and was usually understood. The Brief Interview for Mental Status (BIMS) score was 11 indicating moderate cognitive impairment. The MDS documented, physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days during the assessment period. The behaviors were documented as significantly interfering with the resident's participation activities or social interactions, significantly intruding on the privacy or activity others, and significantly disrupting care or living environment. Resident #1 did not need or want an interpreter to communicate with a doctor or health care staff. Review of an untitled/ undated comprehensive care plan (identified as current by the Director of Nursing (DON)) documented Resident #1 had impaired cognitive function related to dementia. The care plan documented that Resident #1 would be able to communicate their basic needs daily, and interventions included to engage in simple, structured activities that avoid overly demanding tasks. The care plan did not address Resident #1's behaviors. Resident #2 had [DIAGNOSES REDACTED]. The MDS dated [DATE] documented Resident #2 was understood and understands. The BIMS score was 12 indicating moderate cognitive impairment. Resident #2 did not need or want an interpreter to communicate with a doctor or health care staff. Review of an untitled/ undated comprehensive care plan (identified as current by the DON) documented Resident #2 had impaired cognitive function related to dementia. The care plan documented that Resident #2 would be able to communicate their basic needs daily, and interventions included to cue, reorient and supervise as needed; Ask yes/no questions in order to determine the resident's needs. The facility Unknown report (identified by the DON as an Accident and Incident (A/I)) report dated 7/14/20, completed by Licensed Practical Nurse (LPN) #1, documented Resident #1 was in the hallway, engaging in sexual activity with another resident (#2). Resident #1 stated consent was given. The facility New Pressure report (identified by the DON as an (A/I) report dated 7/14/20, completed by Licensed Practical Nurse (LPN) #1, documented Resident #2 was in the hallway, engaging in sexual activity with another resident (#1). Resident #2 was unable to give a description of the incident. During an interview on 8/11/20 at 1:16 PM, the DON stated that she completed the investigation of the incident. Review of the unsigned Investigation for incident that occurred on 7/14/20 provided by the facility revealed that on 7/14/20 at 9:50 PM the DON had received a call from LPN #1, stating two residents (#1, 2) were found in a common area sitting on a loveseat, and Resident #2 was performing a sex act on Resident #1. The DON asked LPN #1 whether the residents were alert and oriented and able to make their own decisions, and if they had a [DIAGNOSES REDACTED].#1 stated both residents had a [DIAGNOSES REDACTED]. Resident #1 stated that he/she did consent to the sexual activity. However, Resident #2 told LPN #1 that he/she had no idea what LPN #1 was talking about, and that he/she wasn't doing anything with another resident. The DON advised LPN #1 to increase rounds on both residents throughout the night and to notify the oncoming shift to continue to closely monitor both residents. During an interview on 8/11/20 at 11:02 AM, LPN #1 stated she was the building supervisor on 7/14/20 when the residents were observed engaging in sexual activity. LPN #1 stated she did not observe the sexual activity, but it was reported to her by Certified Nurse Aide (CNA #1). Residents (#1, 2) were immediately separated, Accident/Incident reports were completed, and the DON was notified. During an interview on 8/11/20 at 11:45 AM, CNA #1 stated that on 7/14/20 she observed Residents (#1 and 2) engaging in a sexual act in the hallway. CNA #1 stated the two residents were separated and LPN #1 was notified. During a telephone interview on 8/11/20 at 12:14 PM, the primary physician for Residents (#1, 2) stated neither of the residents involved were evaluated for capacity after the incident, and both residents overall are probably not able to consent to sexual contact. During an interview on 8/11/20 at 1:16 PM, the DON stated neither Resident #1 nor 2 were evaluated for capacity to consent. In addition, the facility does not have a specific policy and procedure for determining a residents capacity. During an interview on 8/11/20 at 1:49 PM, the Administrator stated determining whether residents have a cognitive impairment is crucial to determine if consent can be given. The Administrator stated, based upon the BIMS score of Resident (#1, 2) consent was implied.
	415.4(b)(1)(i)

F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during an Abbreviated survey (Complaint #NY 552) completed on 8/11/2020, the facility did not ensure that all alleged violations of abuse are reported immediately in accordance with State Law through established procedure for two (Resident #1, 2) of three residents reviewed for abuse reporting. Specifically, the facility did not report within the 2-hour time frame to the New York State Department of Health (NYS DOH) abuse allegations as required for Residents #1 and #2. Refer to F 600 D The findings are: Review of the facility policy and procedure titled Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property revised date 2/2015 documented the following: - Abuse: Shall mean, inappropriate physical contact with a resident, which harms or is likely to cause harm to the resident. Inappropriate physical includes, but is not limited to striking, pinching, kicking, bumping, and or sexual molestation. - Mandatory reporters are those professionals who care for nursing home residents. Those who care for residents include all healthcare workers who provide services to residents. - The requirement to report is immediately upon having a reasonable cause to believe that the abuse has occurred. - The facility should not complete a full investigation before reporting to the NYSDOH. In order to gather the best evidence relevant to the allegation, it is necessary that the NYSDOH be told there is reasonable cause to believe that abuse has occurred. Therefore, timing is important and there should be no delay. 1.

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #1 had [DIAGNOSES REDACTED].#1 had moderate cognitive impairments, usually understands and was usually understood. The MDS documented, physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days during the assessment period. The behaviors were documented as significantly interfering with the resident's participation in activities or social interactions, significantly intruding on the privacy or activity of others, and significantly disrupting care or living environment. The resident did not need or want an interpreter to communicate with a doctor or health care staff. Resident #2 had [DIAGNOSES REDACTED]. The MDS dated [DATE] documented Resident #2 had moderate cognitive impairments, understands and was understood. The resident did not need or want an interpreter to communicate with a doctor or health care staff. The incident report, provided by the Director of Nursing (DON), titled Unknown dated 7/14/20 at 7:20 PM completed by Licensed Practical Nurse (LPN) #1, documented Resident #1 was in the hallway, engaging in sexual activity with Resident #2. The incident report, provided by the DON, titled New Pressure report dated 7/14/20 at 9:46 PM, completed by LPN #1, documented Resident #2 was in the hallway, engaging in sexual activity with Resident #1. During an interview on 8/11/20 at 11:02 AM, LPN #1 stated she was the building supervisor on 7/14/20 when the residents were observed engaging in sexual activity. LPN #1 stated she did not observe the sexual activity, but it was reported to her by Certified Nurse Aide (CNA #1) and Accident/Incident reports were completed. LPN #1 stated the DON was notified of the incident via telephone and was told by the DON not to report the incident to the NYS DOH as that was the responsibility of the DON. During an interview on 8/11/20 at 1:16 PM, the DON stated she completed an investigation of the incident. The undated/ unsigned Investigation for incident that occurred on 7/14/20 provided by the facility documented on 7/14/20 at 9:50 PM the DON received a call from LPN #1 stating that two residents (1,2) were found in a common area sitting on a loveseat; Resident #2 was performing a sex act on Resident #1. Review of the NYS DOH Automated Complaint Tracking System (ACTS) Complaint/Incident Investigation Report revealed Date/Time of occurrence: 7/14/20 at 9:53 PM and was submitted by the facility on 7/16/20 at 1:14 PM. During an interview on 8/11/20 at 1:16 PM, the DON stated allegations involving abuse should be reported to the NYS DOH within 3 hours. In addition, the DON stated an evaluation of Resident #1 and Resident #2 ability to consent was not completed, and it would be considered abuse if a person that doesn't have capacity has a sex act performed upon them. During an interview on 8/11/20 at 1:49 PM, the Administrator stated any allegation involving abuse should be reported to NYS DOH within 2 hours. 415.4(b)(4)