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 _____	05/09/2020

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during a COVID-19 Infection Control Focus Survey (Complaint #[ST] 514) completed on 5/9/20, the facility did not immediately inform the resident's representative(s) when there was a significant change in the resident's status. One (Resident #1) of five residents reviewed for notification had issues. Specifically, the primary responsible party (PRP) was not notified when Resident #1 was tested for COVID-19. Additionally, there was a lack of prompt notification when the resident developed symptoms of COVID-19 which included a fever, lethargy and a decreased appetite. The finding is: Review of a facility policy and procedure titled Resident Change in Condition dated 2/20/18 documented the facility has the ongoing responsibly to assess the resident status and to notify the resident's designated representative of changes in the resident's condition. The change in baseline would result in the licensed nurse contacting the responsible party, examples of such changes include increase in fevers, changes in vital signs, appearance as compared to baseline which would require evaluation by the MD. The notification in a change of condition should be prompt and notifications should be documented in the resident's medical record. 1. Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated 5/1/20 documented the resident was severely cognitively impaired. Review of the comprehensive care plan (CCP) dated 4/7/20 revealed Resident #1 had impaired cognitive function and to communicate with family regarding resident's needs. During an interview on 5/9/20 at 8:49 AM, Liscended Practical Nurse (LPN) #1 stated that he was responsible for the front COVID-19 unit (Autumn View South) and the back unit (Autumn View North) which was supposed to be a non COVID-19 unit. LPN #1 further stated four residents on the non COVID-19 unit (Autumn View North) were now symptomatic and identified Resident #1 as one of them and the resident's symptoms started yesterday. Review of an interdisciplinary (IDT) Progress Note dated 5/6/20 at 3:10 PM completed by the Assistant Director of Nursing (ADON) revealed Resident #1 was tested for COVID-19 d/t (due to) positive cases on the unit. Additionally, the resident was afebrile (without fever) and had no signs or symptoms of respiratory illness. Continued review of the progress notes revealed the resident was administered [MED] on 5/8/20 at 3:12 AM, 7:28 AM, 6:01 PM and 8:29 PM for a fever greater than 100 (degree) F (Fahrenheit) (normal 98.6). On 5/8/20 at 9:01 PM, LPN #4 documented Resident #1 had a fever of 101.8 F, was more lethargic than usual and refused supper. There were no further entries for this resident. Review of the Medication Administration Record [REDACTED] F, 5/8/20 evening shift- 101.8 F, night shift- 101.8 F, 5/9/20 day shift- 101.2 F. Review of Resident #1 entire electronic medical record (eMAR) and paper chart including but not limited to physician orders 5/1/20 to 5/9/20, IDT Progress Notes 4/30/20 to 5/9/20, laboratory data 5/1/20 to 5/9/20, scanned documents, miscellaneous, physician notes revealed there were no physician orders for COVID-19 testing, laboratory results reports related to COVID-19, and no documented evidence the family was notified of the COVID-19 testing or had a change in condition (fever, lethargy with a poor appetite). During an interview on 5/9/20 at 2:30 PM, LPN #1 reviewed Resident #1's electronic medical record and paper chart including but not limited to physician orders, interdisciplinary progress notes, laboratory data, 24- hour nursing reports, and stated there were no physician orders to test Resident #1 for COVID-19, and the laboratory results for COVID-19 were not available. Resident #1 was tested prior for COVID-19 again today because of her change in condition. The responsible party was not notified and should have been regarding the COVID-19 tests and that the resident was symptomatic. A nurse's note should have been written. During a telephone interview on 5/9/20 at 12:40 PM, Resident #1's PRP stated they get a generic letter from the facility regarding an updated number of COVID-19 positive cases and COVID-19 related deaths, but there are no specifics provided. The PRP stated they were not notified and not aware if their mother had been tested for COVID-19 or that she has had any changes in condition. During an interview 5/9/20 at 3:00 PM, the Director of Nurseing (DON) stated the facility only notifies responsible parties if a resident's COVID-19 test comes back positive because of the lack of staff. Resident # 1 was tested for COVID-19 on 5/6/20 and the results came back negative on 5/7, therefore the family was not notified. If a resident however had a change in condition like a fever the responsible party should be notified immediately or at least in the morning. Resident #1 developed symptoms last evening, was swabbed again today, and was not aware the family had not been notified and they should have been. 415.3(e)(2)(ii)(b)(c)
F 0880 **Level of harm** - Immediate jeopardy **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 COVID-19 Infection Control Focus Survey (Complaint #[ST] 514) completed on 5/9/20, it was determined that the facility did not establish and maintain an Infection Control Program to ensure the health and safety of residents to help prevent the transmission of COVID-19. Specifically, facility staff (Certified Nurse Aides (CNA) and Licensed Practical Nurses (LPN)) entered and exited the room of a resident diagnosed with [REDACTED]. The same staff then entered the rooms of residents without COVID-19, passed breakfast trays, assisted with the residents' meal and provided hands on care without wearing PPE and completing proper hand hygiene. Staff on COVID-19 Units, COVID-19 rooms, and COVID-19 presumed rooms were not wearing proper PPE. PPE was not readily accessible to staff. Additionally, resident's under investigation for COVID-19 were not placed on droplet precautions per the facility process. This was a pattern of no actual harm that is immediate jeopardy to resident health and safety. The findings are: Review of the facilities policy and and procedure titled COVID-19 dated 3/12/20 documented the facility would: -Take every precaution to identify signs and symptoms of COVID-19 disease and implement infection control strategies to avoid possible spread of the disease. -Ensure employees clean their hands according to CDC guidelines including before and after contact with residents, after contact with contaminated surfaces and after removing PPE. -Identify dedicated employees to care for COVID-19 residents and provide infection control training. -Provide the right supplies to ensure easy and correct use of PPE, post signs on the door or wall outside the resident rooms to clearly describe what type of precautions are needed and required PPE. -Make PPE including facemask, eye protection, gowns and gloves available immediately outside of the resident's room. -In the event we suspect a resident is infected with COVID-19, staff will utilize N95 mask and eye protection and keep the resident isolated. a.) During an observation on 5/9/20 at 8:07 AM on the Garden View Unit (Rooms #1 to #15) nine of eighteen Residents' had plus (+) signs posted at the door. A stocked linen cart was uncovered, and most of the doors to the resident rooms were open. During an interview on 5/9/20 at 8:10 AM, LPN #2 stated the plus (+) sign posted at the doors indicated the resident was on precautions due to testing positive for COVID-19. During an observation on 5/9/20 at 8:12 am on the Orchard View (Rooms #16 to #28) Unit designated as a COVID-19 Unit revealed CNA #5 was not wearing a face shield or goggles while going in and out of resident's rooms diagnosed with [REDACTED]. During observations on 5/9/20 at 8:14 AM LPN #2 delivered a breakfast tray to an actively coughing resident diagnosed with [REDACTED]. LPN #2 was not wearing gloves and did not complete hand hygiene. LPN #2 then entered a non COVID-19 room while wearing the same uniform and face mask to provide hands on assistance to the resident. LPN #2 assisted the COVID-19

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) negative resident out of bed, stood behind the resident reaching around the residents' torso and hand over hand ambulated the resident to the bathroom with a wheeled walker. During observations on 5/9/20 at 8:15 AM CNA #3 delivered a breakfast tray to a resident diagnosed with [REDACTED]. CNA #3 exited the room did not remove their gloves or perform hand hygiene and searched a condiment caddy and drawers for sugar. While wearing the same gloves, CNA #3 then delivered a breakfast tray to a COVID-19 negative resident's room, assisted the resident to a seated position, and provided meal set up. While wearing the same gloves and without performing hand hygiene, CNA #3 exited the COVID negative room removed linens from an uncovered linen cart. He assisted another COVID-19 negative resident with feeding, touching their utensils while sitting within six feet of resident and with his face mask below the chin. During interviews on 5/9/20 at 8:25 AM and 8:54 AM, CNA #3 stated there was no PPE available, gloves should be changed between residents and hand hygiene should be performed prior to exiting a resident room and face masks should cover the mouth and nose. During an interview on 5/9/20 at 8:28 AM, LPN #2 stated PPE including a N95 (a particulate filtering face mask), gown, gloves, and face shield should be donned (put on) when entering a COVID-19 positive room, doffed (removed) when exiting the COVID-19 positive room, and proper hand hygiene completed. If we have the PPE, then I wear it but most of the time there is no PPE available on the unit. I checked the precaution bins on all three units and the bins are empty. We can't do our jobs the right way if we don't have the supplies. During observations of the precaution bins ([MEDICATION NAME]) at the entrance of Orchard View, Canal View, and Garden View units on 5/9/20 at 8:39 AM revealed there was no available PPE in the precaution bins. During an interview on 5/9/20 at 8:39 AM, the building supervisor RN (Registered Nurse) #1 stated the PPE was stored in a room that only the Director of Nursing (DON) and Assistant Director of Nursing (ADON) have the keys to. Additionally, RN #1 stated there wasn't enough PPE readily accessible to get us through the shift and she was unable to find the extra supplies in the ADON's office. b.) During observations on Autumn view (South) designated as a COVID-19 Unit on 5/9/20 at 8:36 AM, revealed there were three residents in the common areas ambulating, sitting in the hall and sitting in the small lounge area, others were in their rooms. CNA #1 was observed circulating amongst the unit, redirecting and assisting the residents with hands on care that were in the common area and in their resident rooms. CNA #1 was dressed in navy blue scrub pants and a bright pink sweatshirt. CNA #1 was wearing an N95 mask, she did not have on a gown or a face shield. During an interview on 5/9/20 at 8:45 AM, CNA #1 stated Autumn view (South) was a designated COVID-19 Unit. She was responsible for 10 residents (9 of which had a [DIAGNOSES REDACTED].#1 stated she gets confused as to when she should wear a gown and face shield. She thought she should always wear a gown and a face shield when on the COVID-19 unit but gets over heated when she wears them. CNA #1's face shield was sitting on the nurses' desk. During an interview on 5/9/20 at 8:49 AM, LPN #1 stated he was responsible for the front COVID-19 Unit (Autumn View South) and the back unit (Autumn View North) a non COVID-19 unit). LPN #1 stated there was one resident on the COVID-19 designated unit (South) that did not have COVID-19 but the resident did not come out of their room and was pretty much independent. LPN #1 further stated that four residents on the non COVID-19 unit (North) were now symptomatic with fevers and lethargy. When asked how he moves from unit to unit without cross contaminating he stated he does not do hands on care with the residents as he directs the CNA's to provide the hands on care, but he was responsible to pass the medications and complete treatments. LPN #1 stated CNA #1 should be wearing a gown and face shield along with her N95 while working on the COVID-19 unit. When asked why the two of them were not wearing gowns on the COVID-19 unit, LPN #1 stated often there weren't any. During an observation on 5/9/20 at 10:30 AM in the presence of the Director of Nursing (DON) the PPE storage room had: 1,000 surgical masks, 88,500 gloves, 600 powder free gloves, 480 N95 face masks, 1,950 gowns, 308 face shields, 19 pairs of goggles, 1,900 surgical masks, and 100 pairs of booties. Additional supplies included 24 containers of bleach wipes, 18 containers of sanitizing wipes plus 5 packages (80 count), 22 gallons of hand sanitizer, 20- 8 oz refillable bottles of hand sanitizer, 50- 3 oz refillable bottles hand sanitizer. The DON stated that only she and the Assistant Director of Nursing (ADON) had keys to this storage room. The extra PPE for staff when the DON and the ADON were not in the building was kept in the ADON's office. During an observation on 5/9/20 at 10:36 AM, the ADON's office had an 18 inch x 12 inch x 9 inch deep cardboard box with two N95 masks, three to four gowns, a box of gloves and four to five surgical masks. c.) Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated 5/1/20 documented Resident #1 was severely cognitively impaired. Review of the comprehensive care plan (CCP) dated 4/7/20 revealed Resident #1 was a risk for COVID-19, the goal documented the resident would remain asymptomatic. Interventions included to monitor the resident's status. During an interview at 8:49 AM, LPN #1 stated there were four residents on the non COVID-19 unit (North) with fevers and lethargy. During an observation on 5/9/20 at 8:50 AM (Autumn View North) revealed residents were ambulating and co-mingling in the dining areas and hallways. Residents were not wearing face masks and there were no signs posted at any of the resident rooms to alert staff that residents were on precautions. Continued observations of the unit revealed a physical therapy assistant (PTA) was assisting Resident #1 (who was identified by LPN #1 as having symptoms of COVID-19) with morning care. The PTA was observed wearing goggles, a N95 mask, a resident gown over her clothing and having bare arms. After providing directed personal care, removing the gown and completing self hand and arm hygiene, the PTA walked Resident #1 out of their room and sat them down in a chair in the hallway without a mask. During interviews on 5/9/20 at 8:54 AM, CNA #2 and CNA #4 stated they have never worked Autumn View North before today. The nurse gave them report as to who was to get up out of bed. The CNA's were not aware of any residents that had COVID-19 on the unit or if there were any residents showing symptoms. Additionally, there were no signs posted at the doors alerting them to anyone on precautions and there was no available PPE on the unit. During an interview on 5/9/20 at 9:10 AM, PTA #1 stated that she was wearing a resident gown over her clothing as a precautionary measure, because she knew yesterday Resident #1 had a fever and that she scrubbed her arms down after providing morning care. During an interview on 5/9/20 at 10:49 AM, the Director of Nursing (DON) stated staff should absolutely be wearing a gown, gloves, N 95 mask and a face shield on the COVID-19 designated units and in suspected COVID-19 rooms. There should be signage posted at the doors alerting staff for any resident on precautions for COVID-19 or showing symptoms, and there should be available PPE on the units. Additionally, the PPE should be doffed when exiting the room of a resident diagnosed with [REDACTED]. There is a risk of transmission if this does not happen. The facility does practice extended use for gowns, face shields and N95 mask on the COVID-19 designated units. During an interview on 5/9/20 at 2:27 PM CNA #2 stated she had not received any training at the facility regarding their infection control policies/procedures or COVID -19. During an interview 5/9/20 at 3:00 PM, the DON stated, Resident #1 developed symptoms yesterday and was swabbed again today. Residents that are symptomatic on Autumn View North should have signs on their doors alerting staff the need to wear the appropriate PPE. That should have been done last evening when the residents became symptomatic and was not aware that had not happened. PPE should have been made available. Additionally, the DON stated that she did not educate agency staff and was not sure if anyone educated them on the facilities infection control policies, Standard/droplet precautions and COVID-19. A lot of agency staff have been relocated here. During an interview on 5/9/20 at 3:20 PM, the Regional Administrator stated he expected the Agency staff and facility staff to have been educated on the facilities infection control policies, standard/droplet precautions and COVID-19. Agency staff and facility staff should don the appropriate PPE prior to going into a COVID-19 positive room and/or a designated COVID-19 unit per those policies. Staff should doff the PPE when exiting the room of a resident diagnosed with [REDACTED]. During a telephone interview on on 5/9/20 at 3:50 PM, the facilities Medical Director was aware of the multiple people at the facility [DIAGNOSES REDACTED]. He expected the facility staff and Agency staff to wear the appropriate PPE, and follow the facilities policies regarding COVID-19 and infection control practices. He was not aware the Agency staff was not educated, and they should have been. If employees are not following the proper measures for infection control, there is a risk for transmission and spread. 415.19 (b)(1)