SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORLEANS

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PEOPLE OF THE STATE OF NEW YORK,
by LETITIA JAMES, Attorney General
of the State of New York,

Petitioner,

Index No. _____

AFFIDAVIT OF AUDITOR-INVESTIGATOR MILAN SHAH

- against -

COMPREHENSIVE AT ORLEANS LLC d/b/a THE VILLAGES OF ORLEANS HEALTH AND REHABILITATION CENTER, TELEGRAPH REALTY LLC, CHMS GROUP LLC, VILLAGES OF ORLEANS LLC, ML KIDS HOLDINGS LLC, BERNARD FUCHS, JOEL EDELSTEIN, ISRAEL FREUND, GERALD FUCHS, TOVA FUCHS, DAVID GAST, SAM HALPER, EPHRAM LAHASKY, BENJAMIN LANDA, JOSHUA FARKOVITS, TERESA LICHTSCHEIN, and DEBBIE KORNGUT,

Respondents.

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State of New York)
) ss.:
County of New York)

I, MILAN SHAH, being duly sworn, deposes and says:

1. I am a Principal Auditor-Investigator employed by the Office of the New York State Attorney General, Medicaid Fraud Control Unit ("MFCU").

2. I have been an Auditor-Investigator with the MFCU for over 22 years, and have participated in over 50 investigations into the conduct of Medicaid providers, including nursing homes such as The Villages of Orleans Health and Rehabilitation Center.

3. I submit this Affidavit in support of the special proceeding commenced by the Attorney General's Verified Petition seeking, among other things, restitution, disgorgement, and

injunctive relief from Respondents Comprehensive at Orleans LLC d/b/a The Villages of Orleans Health and Rehabilitation Center, Telegraph Realty LLC, CHMS Group LLC, Villages of Orleans LLC, ML Kids Holdings LLC, **Bernard Fuchs**, **Joel Edelstein**, **Israel Freund**, **Gerald Fuchs**, **Tova Fuchs**, **David Gast**, **Sam Halper**, **Ephram Lahasky**, **Benjamin Landa**, **Joshua Farkovits**, **Teresa Lichtschein**, and **Debbie Korngut** (collectively, "Respondents").

4. This Affidavit and the facts stated herein are based upon my personal knowledge and information provided to me by other MFCU employees and, if called as a witness, I could and would testify competently hereto.

5. As detailed herein, the Attorney General's investigation found significant evidence of the following: (1) Respondents David Gast, Sam Halper, and Ephram Lahasky in-fact owned, managed, and controlled Comprehensive at Orleans LLC d/b/a The Villages of Orleans Health and Rehabilitation Center ("The Villages"); (2) The Villages' qualitative ratings dropped precipitously after Respondents took control of the facility in 2015; (3) the New York State Department of Health issued multiple citations to The Villages dating back to 2015, and third-party consultants warned Respondents that The Villages was "At Risk"; (4) The Villages heavily relied on third-party agency workers to provide direct care to residents, and The Villages' levels of employee turnover were exceptionally high; (5) The Villages provided residents with less than the New York State average hours of nursing care, and routinely failed to meet its own staffing requirements, while continuing to admit new residents in the run-up to COVID-19; and (6) residents of The Villages suffered repeat accidents and injuries in a short-time span. MFCU further found that the Individual Respondents[1] transferred over $18,600,000 to themselves during the period January 1,

[1] As used herein, "Individual Respondents" means **Bernard Fuchs**, **Joel Edelstein**, **Israel Freund**, **Gerald Fuchs**, **Tova Fuchs**, **David Gast**, **Sam Halper**, **Ephram Lahasky**, **Benjamin Landa**, **Joshua Farkovits**, **Teresa Lichtschein**, and **Debbie Korngut**.

2015 to June 30, 2022 through a series of related-party transactions involving purported "rent" payments, debt encumbrances, management fees, and direct payments from The Villages' operating account.

Corporate Respondents

The Villages – the Nursing Home Facility

6. The Villages is a domestic limited liability company formed in February 2014 under the laws of the State of New York with offices for the transaction of business located at 14012 Route 31, Albion, New York, 14411. The Villages holds an Operating Certificate issued by the New York State Department of Health ("DOH"), effective January 1, 2015, to operate the 120-bed skilled nursing facility located at the same address, 14012 Route 31, Albion, New York, 14411. A true and correct copy of The Villages' Operating Certificate is attached hereto as **Exhibit 1**.

7. On or around December 17, 2014, The Villages opened a Business Checking account with The Private Bank, account number ending 2408 ("Villages 2408").[2] The Business Entity Account Signature Card for Villages 2408 shows that **Joel Edelstein, David Gast, Sam Halper, Ephram Lahasky,** and **Benjamin Landa** control this account. A true and correct copy of The Villages 2408 Account Signature Card is attached hereto as **Exhibit 2**. As detailed below, based on bank record analysis, MFCU found that the New York State Medicaid Program, the Medicare Program, and other insurers transferred at least $45,168,697 to Villages 2408 via electronic funds transfers ("EFTs") during the period January 1, 2015 to June 30, 2022.

8. On or around November 24, 2014, The Villages opened a Business Checking Account with Five Star Bank, account number ending 5897 ("Villages 5897"). The Five Star Bank

[2] Bank account numbers referenced herein are referred to by the last four digits of the account number in accordance with 22 NYCRR § 202.5(e). Financial documents attached hereto as exhibits are similarly redacted in accordance with 22 NYCRR § 202.5(e).

Limited Liability Company Resolution of Authority for this account shows that **Bernard Fuchs**, **Joel Edelstein,** and **Ephram Lahasky** control this account. A true and correct copy of the Five Star Bank Limited Liability Company Resolution of Authority for Villages 5897 is attached hereto as **Exhibit 3**.

Telegraph Realty – the Real Property Holding Company

9. Telegraph Realty LLC ("Telegraph") is a domestic limited liability company formed in 2014 under the laws of the State of New York, with offices for the transaction of business located at 14012 Route 31, Albion, New York 14411. Telegraph acquired The Villages' real property from Orleans County Health Facilities Corporation ("OCHFC") effective January 1, 2015, owns the real property where The Villages is located, and was formed for that purpose.[3] In total, The Villages and Telegraph paid OCFHC $7,800,000 to purchase the facility's real property and business assets. A true and correct copy of The Purchase and Sale Agreement between OCHFC, on the one hand, and The Villages and Telegraph, on the other hand, is attached to hereto as **Exhibit 4**.

10. Since on or around 2015, Telegraph's members have been as follows: **Bernard Fuchs** (3.32%), **Joel Edelstein** (3.32%), **Israel Freund** (3.32%), **Gerald Fuchs** (3.32%), **Tova Fuchs** (3.32%); Villages of Orleans LLC (20.99%); **Sam Halper** (12.33%); **Ephram Lahasky** (16.6%); **Benjamin Landa** (16.6%); **Teresa Lichtschein** (7.5%), and **Debbie Korngut** (9.16%).[4] A true and correct copy of the Amended and Restated Operating Agreement of Telegraph Realty LLC ("Telegraph Amended Operating Agreement") is attached hereto as **Exhibit 5**.

[3] OCHFC is a local non-profit development corporation established to facilitate Orleans County's sale of the facility. (*See* Ex. 4 at 1.)
[4] Telegraph's Amended and Restated Operating Agreement is undated but states that it became effective in 2015. (*See* Ex. 5 at 2.)

11. Pursuant to the original Operating Agreement of Telegraph Realty LLC, which was superseded by the Amended Operating Agreement, prior to on or around 2015, the members of Telegraph were **David Gast** (25%), **Ephram Lahasky** (37.5%), and **Joshua Farkovits** (37.5%). A true and correct copy of the Telegraph Operating Agreement is attached hereto as **Exhibit 6**.

12. On or around December 29, 2014, Telegraph opened a Business Checking account with The Private Bank, account number ending 3849 ("Telegraph 3849"). The Business Entity Account Signature Card for Telegraph 3849 shows that **David Gast**, **Sam Halper, Ephram Lahasky**, and **Benjamin Landa** control this account. A true and correct copy of the Telegraph 3849 Signature Card is attached hereto as **Exhibit 7**.

CHMS Group – the Management Company

13. CHMS Group LLC ("CHMS Group") is a domestic limited liability company formed in January 2015 under the laws of the State of New York, with offices for the transaction of business located at 600 Broadway, Lynbrook, New York 11563. Upon information and belief, "CHMS" stands for Comprehensive Healthcare Management Services. The owners of CHMS Group assert that it has provided administrative services to The Villages, including purchasing, accounting, insurance, billing, and payroll services, since 2015.

14. Pursuant to the CHMS Group Operating Agreement, the members of CHMS Group are **David Gast** (33.33%), **Sam Halper** (33.34%), and **Ephram Lahasky** (33.33%). The CHMS Group Operating Agreement further provides that **Sam Halper** is the managing member. A true and correct copy of the CHMS Group Operating Agreement (CHMSGROUP_2000217-247) is attached hereto as **Exhibit 8**.

15. On or around February 9, 2018, CHMS Group opened a Payroll Account at the Canadian Imperial Bank of Commerce ("CIBC"), account number ending 8819 ("CHMS 8819").

The Business Entity Account Signature Card for CHMS 8819 shows that **David Gast**, **Sam Halper**, **Ephram Lahasky**, and Michael Neufeld[5] control this account. A true and correct copy of the CHMS 8819 Signature Card is attached hereto as **Exhibit 9**.

16. On or around January 13, 2015, CHMS Group opened a Business Checking Account at JP Morgan Chase Bank, account number ending 3360 ("CHMS 3360"). The Business Signature Cards associated with this account provide that **David Gast**, **Sam Halper**, **Ephram Lahasky**, and Michael Neufeld control this account. True and correct copies of the CHMS 3360 Signature Cards are attached hereto as **Exhibit 10**.

Villages of Orleans LLC – the Gast Pass-Through Entity

17. Villages of Orleans LLC ("Gast LLC") is a domestic limited liability company formed in March 2015 under the laws of the State of New York, with offices for the transaction of business located at 14012 Route 31, Albion, New York 14411.

18. On or about March 9, 2015, Gast LLC opened a Business Platinum Checking Account at JP Morgan Chase Bank, account number ending 2691 ("Gast LLC 2691"). The Business Signature Card associated with this account shows that David Gast is the sole signatory for this account. A true and correct copy of the Gast LLC 2691 Signature Card is attached hereto as **Exhibit 11**.

19. David Gast is the sole signatory on The Business Depository Certificate for Gast LLC 2691 where he is listed as a "Member" of Gast LLC. A true and correct copy of the Gast LLC 2691 Business Depository Certificate is attached hereto as **Exhibit 12**.

[5] Upon information and belief, Michael Neufeld is the Controller of CHMS Group.

20. New York State Department of State records show that David Gast is the individual authorized to accept service of process on behalf of Gast LLC. A true and correct copy of the New York State Department of State Entity Information for Gast LLC is attached hereto as **Exhibit 13**.

ML Kids Holdings LLC – the Holding Company

21. ML Kids Holdings LLC ("Lahasky LLC") is a limited liability company formed in 2018 under the laws of the State of Delaware, with offices for the transaction of business located in Lawrence, New York.

22. On or about March 13, 2018, Lahasky LLC opened a Chase Platinum Business Checking Account at JP Morgan Chase Bank, account number 0890 ("Lahasky 0890"). The Business Signature Card for this account shows that Ephram Lahasky is the sole signatory for Lahasky 0890. A true and correct copy of the Lahasky 0890 Signature Card is attached hereto as **Exhibit 14**.

Individual Respondents

Fuchs Family Group

23. **Bernard Fuchs** is the owner (100%) of The Villages. A true and correct copy of The Villages' Operating Agreement is attached hereto as **Exhibit 15**. **Bernard Fuchs** is a member (3.32%) of Telegraph. (Ex. 5 at Ex. A.)

24. According to The Villages' 2020 CIBC Loan Presentation ("2020 Loan Presentation"), **Bernard Fuchs** reported his net worth to be $43,889,025, as of October 2020. A true and correct copy of excerpted pages 22-23 from the 2020 Loan Presentation is attached hereto as **Exhibit 16**.

25. **Joel Edelstein** is a member (3.32%) of Telegraph. (Ex. 5 at Ex. A.) Upon information and belief, **Joel Edelstein** is **Bernard Fuchs'** son-in-law.

26. **Israel Freund** is a member (3.32%) of Telegraph. (*Id.*) Upon information and belief, **Israel Freund** is **Bernard Fuchs'** son-in-law.

27. **Gerald Fuchs** is a member (3.32%) of Telegraph. (*Id*.) Upon information and belief, **Gerald Fuchs** is **Bernard Fuchs'** son.

28. **Tova Fuchs** is a member (3.32%) of Telegraph. (*Id.*) Upon information and belief, **Tova Fuchs** is **Bernard Fuchs'** daughter-in-law.

29. Together, members of the Fuchs family own 16.6% of Telegraph.

David Gast

30. Gast controls Gast LLC, an entity that holds a 20.99% ownership interest in Telegraph. (*See* ¶¶ 10, 17-20, *supra.*) **David Gast** is a member (33.3%) of CHMS Group. (Ex. 8 at Ex. A.) According to the 2020 Loan Presentation, **David Gast** reported his net worth to be $22,191,047, as of November 2020. (Ex. 16 at 23.)

Sam Halper

31. **Sam Halper** is a member (12.33%) of Telegraph. (Ex. 5 at Ex. A.) **Sam Halper** is the Managing Member (33.4%) of CHMS Group. (Ex. 8 at 4 & Ex. A.)

32. According to the 2020 Loan Presentation, **Sam Halper** reported his net worth to be $22,892,074, as of August 2020. (Ex. 16 at 22.)

Ephram Lahasky

33. **Ephram Lahasky** a/k/a Mordy Lahasky is a member (16.6%) of Telegraph. (Ex. 5 at Ex. A.) **Ephram Lahasky** is a member (33.3%) of CHMS Group. (Ex. 8 at Ex. A.)

34. According to the 2020 Loan Presentation, **Ephram Lahasky** reported his net worth to be $72,737,605, as of September 2020. (Ex. 16 at 22.)

Landa Family Group

35. **Benjamin Landa** is a member (16.66%) of **Telegraph**. (Ex. 5 at Ex. A.) According to The Villages' 2017 CIBC Loan Presentation ("2017 Loan Presentation"), **Benjamin Landa** reported his net worth to be $308,062,231, as of December 2016. A true and correct copy of excerpted pages 9 and 27-29 from the 2017 Loan Presentation is attached hereto as **Exhibit 17**.

36. Prior to on or around 2015, **Joshua Farkovits** was a member (37.5%) of Telegraph. (Ex. 6. at Ex. A.) Upon information and belief, **Joshua Farkovits** is **Benjamin Landa's** son-in-law.

37. Although no longer a formal member of Telegraph per the Amended Operating Agreement, **Joshua Farkovits** continues to receive distributions from Telegraph as if he owned an approximately 8% share (*i.e.*, one-half of his father-in-law **Benjamin Landa's** share). (*See* ¶¶ 179-199, *infra*.)

38. According to the 2017 Loan Presentation, **Joshua Farkovits** reported his net worth to be $21,999,278, as of July 2017. (Ex. 17 at 29.)

39. Together, members of the Landa family group own 16.66% of Telegraph.

Lichtschein Family

40. **Teresa Lichtschein** is a member (7.5%) of Telegraph. (Ex. 5 at Ex. A.)

41. **Debbie Korngut** is a member (9.16%) of Telegraph. (*Id*.) Upon information and belief, **Debbie Korngut** is **Teresa Lichtschein's** daughter-in-law.

42. Together, the Lichtschein family group owns 16.66% of Telegraph.

The New York State Medicaid Program

43. Medicaid is a joint state and federal program designed to provide medical care to those who would not otherwise be able to afford it. It is primarily funded by New York State and

Federal funds. The Medicaid Program provides no-cost medical services and supplies to eligible needy persons. Medicaid beneficiaries must meet defined income or disability thresholds to be eligible for Medicaid.

44. In New York State, Medicaid service providers such as nursing homes are reimbursed either directly, on a fee-for-service basis, a method where providers bill New York State directly for Medicaid services, or through claims submitted to Managed Care Organizations, which manage funds and coverage on behalf of New York. Providers must be enrolled in the Medicaid Program through a process of submitting information and obtaining authorization from DOH, and agreeing to comply with the laws, rules and regulations governing the Medicaid Program.

Gast, Halper, and Lahasky In-Fact Owned, Managed, and Controlled The Villages.

45. On or around January 1, 2015, **David Gast** executed a contract on behalf of The Villages to retain ACM Medical Laboratory to perform laboratory testing services for residents ("ACM Medical Laboratory Contract"). **David Gast** signed the ACM Medical Laboratory Contract as a "member" of The Villages. A true and correct copy of the ACM Medical Laboratory Contract (CHMSGroup_000103-114) is attached hereto as **Exhibit 18**.

46. On or around February 18, 2016, **David Gast** executed a contract on behalf of The Villages to retain AMN Healthcare, Inc. to provide healthcare workers to care for The Villages' residents ("Healthcare Staffing Agreement"). **David Gast** signed the Healthcare Staffing Agreement as a "member" of The Villages. A true and correct copy of the Healthcare Staffing Agreement (CHMSGroup_000178-180) is attached hereto as **Exhibit 19**.

47. On or around November 25, 2015, **Sam Halper** executed a contract on behalf of The Villages to retain Preventative Diagnostics, Inc. to perform portable radiology services for

residents ("PDI Contract"). **Sam Halper** signed the PDI Contract as the "CEO" of The Villages. A true and correct copy of the PDI Contract (CHMSGroup_000186-191) is attached hereto as **Exhibit 20**. Additionally, in 2015, 2016, and 2017, Sam Halper executed annual Medicaid Cost Report Certifications on behalf of The Villages. True and correct copies of The Villages' Medicaid Cost Report Certifications for 2015, 2016, and 2017 are attached hereto as **Exhibit 67**.

48. On or around February 6, 2014, **Ephram Lahasky** executed the Purchase and Sale Agreement with OCHFC as an "Authorized Member" on behalf of The Villages.[6] On or around February 5, 2015, **Ephram Lahasky** further executed the Performance Guaranty appended to the Purchase and Sale Agreement. (Ex. 4 at 35, 38.)

49. On or around May 6, 2014, the U.S. Internal Revenue Service ("IRS") sent a Notice to The Villages assigning The Villages an Employer Identification Number. The Notice is addressed to 'Ephraim M Lahasky Sole MBR." A true and correct copy of the May 6, 2014 IRS Notice is attached hereto as **Exhibit 21**.

50. On or around December 1, 2015, **Ephram Lahasky** executed a Certification Statement for Provider Billing Medicaid ("Medicaid Billing Certification") on behalf of The Villages. By its terms, the Medicaid Billing Certification is an attestation expressly reserved for partners, officers, or directors of the provider. A true and correct copy of The Villages' 2015 Medicaid Billing Certification is attached hereto as **Exhibit 22**.

[6] In addition to executing the Purchase and Sale Agreement for The Villages, Respondent **Lahasky** executed the agreement on behalf of Telegraph. (*See* Ex. 4 at 35.)

**After Respondents Took Control of The Villages,
Its CMS Nursing Home Ratings Dropped In Every Category and
Its Specific Quality Measures Became Among the Worst in the State.**

51. The U.S. Centers for Medicare and Medicaid Services ("CMS") publishes nursing home ratings in the following categories: 1) Health Inspections; 2) Staffing; 3) Quality Measures; and 4) Overall ratings for each nursing home in the country. These ratings are published on the CMS "Care Compare" website.[7] CMS created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily. The ratings are based on required data reported by the facility and on official inspections; the ratings are not matters of consumer opinion.

52. CMS rates each nursing facility on a scale of 1 to 5 stars. CMS designates a 1-Star rating to mean "MUCH BELOW AVERAGE," a 2-Star rating to mean "BELOW AVERAGE," a 3-Star rating to mean "AVERAGE," a 4-Star rating to mean "ABOVE AVERAGE," and a 5-Star rating to mean "MUCH ABOVE AVERAGE."

The Villages' "Overall" Rating Dropped to 1-Star Under Respondents, the Lowest Possible Level.

53. The CMS Overall rating is based on the Health Inspection, Staffing, and Quality Measures ratings.[8] The Villages' CMS star ratings declined in every category when Respondents took over control of The Villages from Orleans County in January 2015.

54. Prior to Respondents' ownership and operation, in October 2014, CMS gave the facility an Overall rating of 3-Stars.

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[7] *See* CMS Care Compare, https://www.medicare.gov/care-compare/ (last accessed Nov. 17, 2022).
[8] *See* CMS Care Compare, Overall Star Rating for Nursing Homes, https://www.medicare.gov/care-compare/resources/nursing-home/overall-star-rating (last accessed Nov. 17, 2022).

55. In February 2015, CMS decreased the Overall rating to 2-Stars.

56. In April 2015, CMS decreased the Overall rating to 1-Star.

57. The Villages maintained a 1-Star Overall rating until March 2021, at which point CMS designated The Villages as a Special Focus Facility ("SFF") – a designation reserved for the poorest performing nursing homes in the country. (*See* ¶ 97, *infra* [describing the SFF program].)

The Villages' "Health Inspections" Ratings Dropped to 1-Star Under Respondents, the Lowest Possible Level.

58. CMS' Health Inspections rating is based on each nursing home's current health inspection and two prior inspections, as well as findings from the most recent three years of complaint inspections and three years of infection control inspections.[9]

59. Prior to Respondents' ownership and operation, in October 2014, CMS gave the facility a 2-Star Health Inspections rating.

60. In April 2015, after Respondents assumed ownership and operation, CMS decreased The Villages' Health Inspections rating to 1-Star.

61. In December 2018, CMS increased the Health Inspections rating to 2-Stars.

62. In November 2019, CMS reduced the Health Inspections rating to 1-Star.

63. The Villages maintained a 1-Star Health Inspections rating until March 2021 when CMS designated The Villages as an SFF.

The Villages' "Staffing Rating" Dropped to 1-Star Under Respondents, the Lowest Possible Level.

64. CMS' Staffing rating is based on measures including: (1) Registered Nurse ("RN") hours per resident per day in a three-month period; and (2) total nurse staffing hours per resident

[9] *See* CMS Care Compare, Health Inspections for Nursing Homes, https://www.medicare.gov/care-compare/resources/nursing-home/health-inspections (last accessed Nov. 17, 2022).

per day in a three-month period (including RNs, Licensed Practical Nurses ("LPNs") and Certified Nurse Aides ("CNAs")). The CMS Staffing rating also considers, *inter alia*, total nurse, RN, and administrator turnover in a given year.[10]

65. Prior to Respondents' ownership and operation, in October 2014, CMS gave the facility a 4-Star Staffing rating.

66. In February 2015, CMS decreased the Staffing rating to 3-Stars.

67. In April 2015, CMS decreased the Staffing rating to 1-Star.

68. In October 2015, CMS increased the Staffing rating to 2-Stars.

69. In December 2016, CMS decreased the Staffing rating to 1-Star.

70. The Villages maintained a 1-Star Staffing rating until March 2021 when CMS designated The Villages as an SFF.

The Villages Has Had Low "Quality Measures" Ratings Under Respondents and Scored Poorly on Specific Resident Quality Measures.

71. CMS' Quality Measures rating measures each nursing home's performance in certain areas of care, for example whether residents have gotten their flu shots, are in pain, or are losing weight. The Quality Measure star rating is calculated from two different types of quality measures: short- and long-stay resident quality measures.[11]

[10] *See* CMS Care Compare, Staffing for Nursing Homes, https://www.medicare.gov/care-compare/resources/nursing-home/staffing (last accessed Nov. 17, 2022).

[11] Short-stay residents are often those recovering from surgery or being discharged from a hospital stay. Many short-stay residents get care in a nursing home until they're able to go back home or to the community. Long-stay residents are usually not healthy enough to leave a nursing home and can't live at home or in a community setting. These residents may be older and have more serious health issues. (*See* CMS, Quality Measures, https://data.cms.gov/provider-data/topics/nursing-homes/quality-of-resident-care/#short-stay-quality-of-resident-care-measures [last accessed Nov. 17, 2022].)

72. According to MFCU's analysis of CMS Star ratings data for 2021, nearly 80% of nursing homes in New York State that participate in Medicaid or Medicare received a Quality Measure rating of 4-Stars or above.

73. Prior to Respondents' ownership and operation, in October 2014, CMS gave the facility a 4-Star Quality Measures rating.

74. In February 2015, CMS decreased the Quality Measures rating to 3-Stars.

75. In April 2015, CMS decreased the Quality Measures rating to 1-Star.

76. In October 2015, CMS increased the Quality Measures rating to 2-Stars.

77. In December 2016, CMS decreased the Quality Measures rating to 1-Star.

78. In December 2017, CMS increased the Quality Measures rating to 3-Stars.

79. In November 2019, CMS decreased the Quality Measures rating to 2-Stars.

80. In November 2020, CMS increased the Quality Measures rating to 3-Stars.

81. The Villages maintained a 3-Star Quality Measures rating until March 2021 when CMS designated The Villages as an SFF.

The Villages Scored Poorly on Specific Resident Quality Measures.

82. During the relevant period, CMS utilized nine long-stay and six short-stay resident quality measures ("QMs") to calculate the Quality Measures Star rating.[12] These QMs address a broad range of function and health status indicators. CMS assigns points for each QM based on clinical data reported by the nursing home on Minimum Data Set ("MDS") reports[13] and Medicare

[12] *See* CMS, Quality Measures, https://data.cms.gov/provider-data/topics/nursing-homes/quality-of-resident-care/#short-stay-quality-of-resident-care-measures (last accessed Nov. 17, 2022).
[13] MDS assessment is a federally mandated process used to evaluate patients in Medicaid- and Medicare-certified nursing homes. Assessments are conducted by trained nursing home clinicians upon admission and discharge, as well as at other regular intervals and when there is a significant change in the status of a patient.

claims data submitted for payment. As shown below, The Villages' residents were consistently at a much higher risk of injury and poor care than at other nursing homes in New York State.[14]

The Villages' Residents Consistently Suffered More Falls with Major Injuries Than the Vast Majority of Residents at Other Nursing Homes.

83. Percentage of long-stay residents experiencing one or more falls with major injury: This QM reports the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period or look-back period (one full calendar year).[15]

84. The Villages' residents consistently suffered more falls with major injuries than in other nursing homes in New York State. In 2018, The Villages' four-quarter average score for this QM was in the bottom 20% of all New York State nursing homes that participate in the Medicaid or Medicare Programs. In 2019, The Villages' average score was in the bottom 5%. In 2020, The Villages' average score was in the bottom 15%. In 2021, The Villages' average score was in the bottom 20%.

More Residents at The Villages Suffered Pressure Ulcers Than at Other Nursing Homes.

85. Percentage of high-risk long-stay residents with pressure ulcers: This measure captures the percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers.[16] More Villages residents suffered pressure ulcers than at other nursing homes. In 2019,

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[14] CMS publishes QM scoring data for nursing homes that participate in the Medicaid or Medicare Programs at the following website: https://data.cms.gov/provider-data/ (last accessed Nov. 17, 2022).

[15] *See* CMS, *Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide* (Oct. 2022) ["Care Compare Technical Users' Guide"] at 17, available at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf [last accessed Nov. 17, 2022].

[16] Pressure ulcers, also known as "pressure sores," "pressure injuries," or "bed sores" are areas of damaged skin caused by long-term pressure, such as staying in one position for too long. Residents at high risk for pressure ulcers are those who are impaired in bed mobility or transfer,

The Villages' four-quarter average score for this QM was in the bottom 30% statewide. In 2020, The Villages' average score for this QM was in the bottom 10%, meaning that the number of long-stay, high-risk residents suffering from pressure ulcers was higher than nine out of ten nursing homes.

86. Percentage of SNF residents with pressure ulcers/pressure injuries that are new or worsened: This measure captures the percentage of short-stay residents with pressure ulcers that are new or whose existing pressure ulcers worsened during their stay in the SNF and includes unstageable ulcers.[17] In 2018 and 2019, respectively, The Villages scored in the bottom 5% statewide. During the period July 1, 2020, to June 30, 2021, The Villages scored in the bottom 10%, meaning that the number of short-stay residents suffering from new or worsened pressure ulcers was higher at The Villages than nine out of ten nursing homes in New York State.

The Villages Used Antipsychotic Medications More Than Other Nursing Homes.

87. As detailed in the Affidavit of Medical Analyst Jennifer Cronkhite, R.N. ("Medical Analyst Aff."), psychotropic drugs frequently act as a chemical restraint by causing side effects such as lethargy, increased falls, abnormal involuntary movements, lack of socialization, and a decline in physical function. Improper use of physical or chemical restraints can lead to life-threatening injuries and/or death. Moreover, restraints can lead to a resident becoming emotionally withdrawn and cause them to experience a decrease in their self-esteem and, in turn, their quality of life. (*See* Medical Analyst Aff. ¶¶ 161-164.)

88. Percentage of long-stay residents who received an antipsychotic medication: This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the

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who are comatose, or who suffer from malnutrition. (*Id.* at 17; *see also* Affidavit of Jennifer Cronkhite, R.N. ¶ 153 [describing four stages used to categorize pressure injuries].)

[17] *See* Care Compare Technical Users' Guide at 18.

target period.[18] In 2018 and 2020, respectively, The Villages' four-quarter average score for this QM was in the bottom 15% statewide. In 2019 and 2021, The Villages' average score was in the bottom 10%.

89. Percentage of short-stay residents who newly received an antipsychotic medication: This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.[19] In 2018, The Villages' average score for this QM was in the bottom 20% statewide. In 2019 and 2020, The Villages' average score was in the bottom 15%. In 2021, The Villages' average score was in the bottom 10%.

The Villages' Residents Visited the Emergency Room Significantly More Often Than Residents in Other Nursing Homes.

90. Number of outpatient emergency department visits per 1,000 resident days:[20] This measures the number of outpatient emergency department visits that occurred among long-stay residents of a nursing home during a one-year period, expressed as the number of outpatient emergency department visits for every 1,000 days that the long-stay residents were admitted to the nursing home.[21] In 2018 and 2021, respectively, The Villages scored in the bottom 5% statewide. This means that 95% of New York nursing homes scored better than The Villages in this area. In 2019, The Villages scored in the bottom 20%.

91. Percentage of short-stay residents who have had an outpatient emergency department visit: This measure reports the percentage of all new admissions or readmissions to a

[18] *See id.* at 17.
[19] *See id.* at 18.
[20] The emergency department and hospitalization QMs (¶¶ 90-92, *infra*) are risk-adjusted to incorporate Medicare enrollment data, Part A claims, and information from clinical assessments. (*See* Care Compare Technical Users' Guide at 16.)
[21] *See id.* at 18.

nursing home from a hospital where the resident had an outpatient emergency department visit (*i.e.*, an emergency department visit not resulting in an inpatient hospitalization) within 30 days of entry or re-entry.[22] In 2018, The Villages scored in the bottom 20% statewide. In 2021, The Villages scored in the bottom 5%.

The Villages' Residents Were Admitted to the Hospital More Often.

92. Number of hospitalizations per 1,000 resident days: This QM measures the number of unplanned inpatient admissions or outpatient observation stays that occurred among long-stay residents of a nursing home during a one-year period, expressed as the number of unplanned hospitalizations for every 1,000 days that long-stay residents were admitted to the nursing home.[23] In 2019 and 2021, The Villages scored in the bottom 10% in New York State for this QM.

The Villages Had Fewer Successful Discharges.

93. Rate of successful return to home and community from a SNF: This measure reports the rate at which residents returned to home and community with no unplanned hospitalizations and no deaths in the 31 days following discharge from the SNF.[24] During the period October 1, 2016, to September 30, 2018, The Villages ranked in the bottom 20% statewide for this QM.

Residents' Ability to Perform ADLs and Move Independently Worsened at The Villages.

94. Percentage of long-stay residents whose need for help with daily activities has increased: This measure reports the percentage of long-stay residents whose need for help with late-loss Activities of Daily Living ("ADLs") increased when compared to the prior assessment. The late-loss ADLs are bed mobility, transfer, eating, and toileting. Per CMS, maintenance of

[22] *See id.*
[23] *See id*.
[24] This QM is risk-adjusted based on Medicare enrollment data and Part A claims. (*See id.* at 16, 18.)

ADLs is related to an environment in which the resident is up and out of bed and engaged with activities.[25] Further, a 2001 CMS staffing study found that higher staffing levels were associated with lower rates of increasing ADL dependence.[26] In 2018, The Villages' four-quarter average score for this QM was in the bottom 25% in New York State.

95. Percentage of long-stay residents whose ability to move independently worsened: This measure is a change measure that reports the percentage of long-stay residents who have demonstrated a decline in independence of locomotion when comparing the target assessment to a prior assessment. Residents who lose mobility may also lose the ability to perform other activities of daily living, like eating, dressing, or getting to the bathroom.[27] In 2020, The Villages' four-quarter average score for this QM was in the bottom 30% statewide.

CMS Designated The Villages as a Special Focus Facility in March 2021.

96. In March 2021, CMS designated The Villages as a Special Focus Facility (SFF) due to its history of serious quality issues.

97. According to CMS, the SFF program addresses facilities that have "[m]ore problems than other nursing homes (about twice the average number of deficiencies)," "[m]ore serious problems than other nursing homes (including harm or injury experienced by residents)," and "[a] pattern of serious problems that has persisted over a long period of time (as measured over approximately three years before the date the nursing home was first put on the SFF list)."[28]

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[25] *See id.* at 17.
[26] *See* AM Kramer, R. Fish, *The Relationship Between Nurse Staffing Levels and the Quality of Nursing Home Care*, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report (2001).
[27] *See* Care Compare Technical Users' Guide at 17.
[28] *See* CMS, *Special Focus Facility Program*, at 1, available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf (last accessed Nov. 17, 2022).

The program is further designed to address facilities with a history of "yoyo," or "in and out" compliance.[29]

98. While designated as an SFF, until on or around April 2022, The Villages was not rated by CMS.

99. On or around April 2022, CMS removed The Villages from the SFF list.

100. As of November 1, 2022, The Villages had a 1-Star Health Inspections rating, a 1-Star Staffing rating, a 2-Star Quality Measures rating, and a 1-Star Overall rating.

The Villages Has Received Multiple Citations from DOH Dating Back to 2015.[30]

101. In a survey completed on July 31, 2015, just seven months after Respondents took over operation of The Villages, a DOH surveyor observed mold on food items and other areas of the walk-in cooler; storage of undated, outdated, unlabeled, and uncovered food items; suboptimal temperatures in the cooler; soiled floors; flies; dirty and wet pans stored for use; and bearded dietary staff who were not wearing beard covers during meal preparation in the kitchen. The surveyor further observed a refrigerator labeled "Resident's [sic] refrigerator" that "smelled of rotten food" and contained undated and severely outdated items. Villages' staff members did not know who among them was responsible for cleaning the residents' refrigerator. A true and correct copy of the Statement of Deficiencies, Exit Date July 31, 2015, is attached hereto as **Exhibit 23**.

102. On October 13, 2015, a DOH surveyor found that The Villages failed to notify the facility's physicians and a resident's family in an instance where the resident ran a fever for an

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[29] *See id*.

[30] The New York State Department of Health (DOH) governs nursing home licensure in the state and is responsible for conducting on-site inspections (also known as surveys) to monitor the quality of care and life for nursing home residents, both for purposes of certification and in response to complaints and incidents at the facility. (*See* DOH, About Nursing Home Reports, https://www.health.ny.gov/facilities/nursing/about_nursing_home_reports.htm#request_survey [last accessed Nov. 17, 2022].)

extended period and experienced difficulty swallowing. The surveyor additionally observed that the same resident did not receive a wound consultation for a worsening pressure sore as ordered by The Villages' physician. A true and correct copy of the Statement of Deficiencies, Exit Date October 13, 2015, is attached hereto as **Exhibit 24**.

103. In DOH's annual survey of The Villages completed on April 25, 2016, DOH surveyors observed multiple deficiencies, including deficiencies involving dignity and respect of the individual, failure to develop and implement comprehensive care plans, and failure of qualified persons at The Villages to provide services per residents' care plans. As examples, surveyors observed the following: (1) lack of timely assistance to residents during meals; (2) failure to update a resident's care plan to address the use of an anticoagulant (medications used to prevent blood from clotting) medication, including monitoring for signs of bleeding; (3) failure to revise residents' care plans for the increased level of assistance required to eat, for a change in dosage of a psychotropic medication and the need for increased assistance to eat, for the development of a urinary tract infection (UTI), and for the physical aggressiveness of a resident towards other residents and staff; (4) CNAs did not wash hands or change gloves after providing incontinence care; (5) failure to provide a right palm guard, per a resident's care plan, to prevent worsening contractures from occurring for a resident with a splint application; and (6) resident at risk for aspiration (taking foreign matter into the lungs) because resident was not positioned in a manner that was conducive for eating or swallowing and was coughing and choking intermittently throughout meals. During the same inspection, the DOH surveyor observed that residents reviewed for pressure sores had a seven-day delay in the initiation of treatment, there was no evidence of a proper weekly RN wound assessment, and preventative wound care measures were not in place as

ordered in a resident's care plan. A true and correct copy of the Statement of Deficiencies, Exit Date April 25, 2016, is attached hereto as **Exhibit 25**.

104. In a survey completed on June 22, 2017, DOH surveyors confirmed that staff at The Villages did not follow the care plan of a resident who had a history of starting fights with other residents. Specifically, The Villages failed to provide one to one supervision of that resident when out of bed, per the resident's care plan. Because of The Villages' failure to follow the resident's care plan, the resident wandered undetected to another unit, striking another resident three times in the chest before staff intervened. A true and correct copy of the Statement of Deficiencies, Exit Date June 22, 2017, is attached hereto as **Exhibit 26**.

105. In a survey completed on July 12, 2017, a DOH surveyor observed that The Villages did not properly screen employees for abuse through the New York State Nurses Aide Registry. The surveyor further observed that The Villages did not ensure that a resident with a pressure sore received the necessary treatment and services to promote healing because The Villages did not complete wound treatment as ordered by the physician. A true and correct copy of the Statement of Deficiencies, Exit Date July 12, 2017, is attached hereto as **Exhibit 27**.

106. In an inspection completed on February 21, 2018, after a complaint was filed on February 13, 2018, DOH surveyors found that nursing staff at The Villages failed to notify the medical doctor of a "change in condition" of a resident. That innocuous sounding "change in condition" was the fact that the resident experienced abdominal distension with multiple episodes of vomiting, rectal bleeding, weakness, and abnormal vital signs, and had died before the resident could be transported to the hospital. In addition, the surveyor found no evidence that The Villages notified the resident's physician of a skin condition or completed a proper assessment of the condition, and that nursing staff applied a skin treatment without the physician ordering such

treatment. A true and correct copy of the Statement of Deficiencies, Exit Date February 21, 2018, is attached hereto as **Exhibit 28**.

107. In DOH's annual survey completed on November 16, 2018, DOH surveyors cited The Villages for, among other things: (1) failing to promote self-determination because residents were not given the choice of how often they wanted to shower (specifically, the opportunity to shower more than once a week); (2) failing to maintain a clean, comfortable, homelike environment because hot water was not being provided for bathing and bathroom facilities were not properly cleaned and maintained; (3) failing to properly develop care plans to address residents' behavioral issues and use of psychotropic medications; (4) failing to provide CPAP treatment as ordered by the doctor and failing to repair a broken CPAP machine, and (5) failing to remove an employee from duties involving direct care in accordance with the DOH criminal history record check process. A true and correct copy of the Statement of Deficiencies, Exit Date November 16, 2018, is attached hereto as **Exhibit 29**.

108. On April 2, 2019, approximately one year before the COVID-19 pandemic, DOH conducted an inspection in response to a complaint filed on January 18, 2019. Surveyors observed that The Villages did not have sufficient staff to complete 15 showers, to monitor the dining room, to assist residents with their toileting needs and to properly feed 11 residents. A true and correct copy of the Statement of Deficiencies, Exit Date April 2, 2019, is attached hereto as **Exhibit 30**.

109. As part of this inspection, DOH surveyors interviewed numerous CNAs who stated that The Villages is often short-staffed and residents suffer as a result:

- "I worked on Canal View today and I did not get any of my showers done. There were four Residents that didn't receive them. I worked as hard as I could, but I just

could not do the showers. I was the only CNA over there, we were short staffed. We are short staffed a lot of the times."

- "I am the only CNA on Orchard View today. I was not able to get the showers done today. I had three residents scheduled to have showers done today. We are short staffed today. Also, I was not able to toilet Resident #1 every two to three hours today and I just got to him and he was incontinent. Normally if I am able to toilet him as scheduled he is not incontinent."
- "I was not able to complete any of my showers today on Garden View. There were three residents scheduled to be showered, that I was not able to get done. Residents' hair didn't get done either. I was the only aide over there, we are very short staffed today. I had my nurse help me with the two assists. We are short staffed quite often."
- "I was not able to get all my work done today because we were short staffed. I was not able to get any of my showers done today I had five showers scheduled for today. There are thirty residents for only two aides and five showers over here on Autumn View North today. I didn't even take a lunch today. They are normally short staffed. Sometimes we have two CNAs on each unit and on a rare occasion three. When we have three aides, those are the days we will do nails and hair."

(Ex. 30.)

110. Also on April 2, 2019, DOH surveyors observed a resident whose care plan called for supervision while eating due to aspiration risk, and who had been ordered a puree/ honey thick liquid diet, take a sandwich from another resident's meal tray and eat it. An LPN in the dining room stated "[t]his isn't the first time he has done this. He often grabs at things . . . I wasn't

watching him because I was busy passing other resident's [sic] trays because we are short staffed today." (*Id*.)

111. In the Statement of Deficiencies, DOH surveyors further noted that several residents at The Villages "had an odor" because they had not been bathed. (*Id*.)

112. On April 2, 2019, DOH surveyors further found that all five units in the facility did not have sufficient staff and failed to meet The Villages' Facility Assessment.[31] DOH also reviewed The Villages' Daily Staffing Worksheets from March 1, 2019 through March 31, 2019 and found the following: (1) Day shift CNA levels per the Facility Assessment were not met for eight out of the 31 days; (2) Evening shift CNA levels per the Facility Assessment were not met six out of the 31 days; (3) Night shift CNA levels per the Facility Assessment were not met 19 out of the 31 days; (4) Day and Evening shift LPN levels per the Facility Assessment were not met two out of the 31 days; and (5) Night shift LPN levels per the Facility Assessment were not met 14 out of the 31 days. (*Id*.)

113. In an abbreviated survey completed on July 9, 2019, surveyors again found The Villages did not have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. DOH found that The Villages did not meet the minimum standards they set for nursing services staff as documented in the Villages' Facility Assessment Tool and did not meet the minimum standards set for CNAs as documented in the facility's Critical Staffing Plan. Through review of staffing "Worksheets," as well as observations and interviews, DOH found numerous incidents of insufficient staffing levels

[31] As discussed below, The Villages' Facility Assessment Tool is an internal Villages' document prescribing necessary staffing levels "to ensure residents needs are practicably met." (*See* Ex. 45.)

in June and July 2019, substantiating a finding of federal deficiency for insufficient nursing staff. A true and correct copy of the Statement of Deficiencies, Exit Date July 9, 2019, is attached hereto as **Exhibit 31**.

114. On May 9, 2020, DOH conducted an on-site survey at The Villages resulting in an "Immediate Jeopardy" finding due to infection control violations. Immediate Jeopardy means "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (42 CFR § 488.301.) Among other things, the surveyor found that The Villages "failed to protect asymptomatic non-COVID-19 residents" after observing multiple staff members who were not wearing proper PPE or observing proper hand hygiene while providing care to residents. A true and correct copy of the Statement of Deficiencies, Exit Date May 9, 2020, is attached hereto as **Exhibit 32**.

115. DOH surveyors further observed CNAs and LPNs exiting a COVID-19 positive room and entering COVID-19 negative rooms while serving breakfast trays, assisting with trays, and providing care without PPE and completing proper hand hygiene. Surveyors also observed that PPE was not readily accessible to staff and that residents under investigation for COVID-19 were not placed on droplet precaution. (*See* Ex. 32)

116. Surveyors further observed that The Villages did not notify the responsible party when a resident tested positive for COVID-19 and did not provide timely notification to the responsible party when the resident developed symptoms of COVID-19. (*See id*.)

117. Due to the serious nature of The Villages' noncompliance with applicable nursing home infection control requirements, The Villages was fined for violating PHL § 2803(4), 10 NYCRR §§ 415.3(f)(2)(ii)(b) and 415.3(f)(2)(ii)(c), 415.19(a)(1), 415.19(a)(2), 415.19(b)(1) and

Governor's Executive Order 202.11. A true and correct copy of the Stipulation and Order, NH-20-018, is attached hereto as **Exhibit 33**.

118. In an inspection completed on August 12, 2020, DOH surveyors found that the Villages failed to perform criminal history record checks for prospective employees. Specifically, the facility did not initiate the background check process in a timely manner for one of six new/prospective employees reviewed for compliance with the DOH Criminal History Record Check ("CHRC") process. The facility did not-submit fingerprints in a timely manner for two of six new/prospective employees reviewed for compliance with the CHRC process. Additionally, one employee of six prospective employees viewed for supervision pending the results of criminal history record checks did not have evidence of weekly supervision as required. A true and correct copy of the Statement of Deficiencies, Exit Date August 12, 2020, is attached hereto as **Exhibit 34**.

119. On December 17, 2020, DOH again conducted an on-site survey resulting in deficiencies because The Villages failed to establish and maintain an infection control program under which it investigates, controls, and takes action to prevent infections in the facility. The Villages failed to require all staff to be checked for COVID-19 symptoms, including a temperature check at the start of each shift and every 12 hours while on duty pursuant to DOH's directives. The Villages also failed to perform weekly testing of three staff for COVID-19 and to ensure that facility staff wore proper PPE when conducting COVID-19 swabbing. A true and correct copy of the Statement of Deficiencies, Exit Date December 17, 2020, is attached hereto as **Exhibit 35**.

120. On February 3, 2021, DOH found The Villages civilly liable for repeat violations of 10 NYCRR § 415.4(b)(1)(i) for permitting sexual abuse of residents, and failure to ensure that

allegations of abuse are reported within two hours after the allegation is made. A true and correct copy of the DOH Enforcement Letter, dated February 3, 2021, is attached hereto as **Exhibit 36**.

121. Specifically, in an inspection completed on September 24, 2019, in response to a complaint made on September 10, 2019, DOH surveyors found that The Villages failed to report to the DOH an allegation of sexual abuse perpetrated by a male resident against a female resident within two hours of the allegation, but instead reported the alleged incident more than 24 hours after receiving the allegation. A true and correct copy of the Statement of Deficiencies, Exit Date September 24, 2019, is attached hereto as **Exhibit 37**.

122. A February 26, 2020 DOH survey found that The Villages failed to timely investigate an incident of alleged sexual abuse. DOH surveyors found that an LPN did not report an alleged sexual abuse of a resident to the supervisor the night she was informed of the alleged incident. The Administrator in turn did not report the allegation to the DOH until the day after he was informed of the alleged sexual abuse. Additionally, the facility failed to ensure that the alleged perpetrator no longer had access to the resident victim's room, even after the resident requested that the facility prohibit visitation. A true and correct copy of the Statement of Deficiencies, Exit Date February 26, 2020, is attached hereto as **Exhibit 38**.

123. Again, in a survey completed on August 11, 2020, in response to a complaint filed on July 16, 2020, DOH surveyors found that two residents who lacked the ability to consent to sexual activity engaged in such activity with one another and, per facility policy, The Villages did not evaluate the two residents for capacity to consent after the activity occurred. Furthermore, The Villages did not report this incident to the DOH within two hours of learning about this abuse allegation. A true and correct copy of the Statement of Deficiencies, Exit Date August 11, 2020, is attached hereto as **Exhibit 39**.

124. In a survey completed on April 26, 2021, DOH surveyors again found that The Villages failed to timely investigate and report abuse and neglect allegations to DOH. The surveyors further found that a care plan was not developed for the use of anticoagulant medication and antipsychotic medication for certain residents, meaning that staff did not know how to guide their care for safety, interventions, and side effects of medications. During that same survey, surveyors found that one resident received Haldol[32] without a physician's order and another resident did not receive lab work per the physician's order. Surveyors also found that the facility failed to provide a resident who was fed by enteral means with nutritional assessments and weight monitoring to ensure that the resident's nutritional needs were being met. A true and correct copy of the Statement of Deficiencies, Exit Date April 26, 2021, is attached hereto as **Exhibit 40**.

125. In that same survey completed on April 26, 2021, DOH surveyors found that the facility did not conduct annual Legionella culture sampling and analysis, despite the fact that in its annual inspection completed on November 16, 2018, DOH found that The Villages did not complete a legionella sampling, and in a Recertification survey completed on September 14, 2020, DOH again found that The Villages did not conduct a complete Legionella risk assessment and did not have a water management plan in place to reduce the risk of growth and spread of Legionella.

126. In an inspection completed on October 25, 2021, after complaints were filed in June and July of that year, DOH surveyors observed that The Villages failed to ensure each resident received adequate supervision and assistance with devices to prevent accidents. Surveyors observed a resident transferred by staff without the use of a gait belt,[33] which created an accident

[32] Haldol is an antipsychotic medication used to treat Schizophrenia, among other conditions.
[33] A gait belt is a device used to help safely assist residents with sitting and standing.

hazard. Surveyors also found that The Villages did not honor residents' wishes regarding life-sustaining treatment as set forth in those residents' advanced directives. A true and correct copy of the Statement of Deficiencies, Exit Date October 25, 2021, is attached hereto as **Exhibit 41**.

Consultants Warned Respondents that The Villages was "At Risk."

127. In 2019, The Villages' lender, Housing and Healthcare Finance, LLC, commissioned an "on-site risk management assessment" performed by Quality In-cite, LLC ("In-cite") in connection with Respondents' efforts to secure a mortgage re-financing. The primary purpose of the assessment was to review the overall clinical, regulatory, and operational performance of The Villages. In making its assessment, In-cite relied on "operator reports," three years of survey history, CMS Five-Star Rating information available on the CMS/Data.gov web sites, and on-site interviews with "facility leadership." In-cite's analysis, as reflected in its On-Site Risk Management Assessment, dated March 15, 2019 ("2019 In-cite Report"), found The Villages to be "At Risk." The report emphasized that The Villages had, on average, more life safety survey deficiencies[34] from DOH than the average for New York nursing homes in 2016, 2017, and 2018; 16 repeat citations in numerous categories including multiple violations pertaining to (i) services not provided by qualified personnel; (ii) services and treatment not provided to prevent and/or heal pressure sores (ulcers); (iii) failure to supervise to prevent accidents; (iv) incomplete and inaccurate clinical records; and (v) failure to properly release and/or maintain residents' medical and non-medical status. A true and correct copy of the 2019 In-cite Report is attached hereto as **Exhibit 42**.

[34] Life safety surveys include evaluation of factors such as fire alarms, sprinkler systems, evacuation plans, and electrical hazards.

128. The 2019 In-cite Report also made specific findings and recommendations designed to ensure The Villages provided proper care to residents, including: (1) implementation of a formalized Performance Improvement Plan with appropriate monitoring tools to decrease the percentage of weight loss, wounds, antipsychotics, and anxiolytic/hypnotics among residents; (2) address root causes to "mitigate repeat life safety deficiencies"; (3) establish regional/corporate oversight and review policies and procedures on an annual basis; (4) adhere to The Villages' Quality Assurance/Performance Improvement ("QAPI")[35] plan policy; (5) develop a formal survey for both short-term and long-term residents, and review results of those surveys during QAPI meetings and develop action plans as appropriate to address areas of concern; (6) consider a comprehensive weekly risk meeting to review those residents that are triggering in high risk care areas to ensure resident condition is reviewed, and documentation, care plans, interventions, notifications, and orders are appropriate and implemented; and (7) obtain informed consents from residents and/or responsible parties prior to utilizing psychotropic medications. (Ex. 42.)

129. The 2019 In-cite Report also confirmed serious and chronic understaffing at The Villages, making the following staffing recommendations: (1) review staffing levels and conduct an analysis of resident acuity and dependency to ensure staffing is appropriate to meet the needs of the residents; (2) implement formalized staffing improvement plans; (3) add a full-time Staff Development Coordinator to oversee training and in-servicing of staff; (4) enroll Activity Director in a required certification course, and confirm whether the Dietary Manager completed their

[35] "QAPI is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving. (CMS, QAPI Description and Background, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition [last accessed Nov. 17, 2022].)

required Certified Dietary Manager course; and initiate regional/corporate support visits and to review MDS assessments to ensure accuracy given that The Villages' MDS nurse had no prior experience in completing MDS assessments. (*Id*.)

130. In May 2020, The Villages hired another third-party healthcare consulting company, Polaris Health, LLC, d/b/a Polaris Group ("Polaris"), to provide Respondents with a risk management assessment report in connection with their re-financing efforts. Like In-cite, a Polaris consultant also found that The Villages lacked appropriate systems to monitor and adhere to regulatory standards and provide proper care to residents. Specifically, after three days of visiting The Villages from June 23rd to 25th, 2020, a Polaris consultant found that The Villages scored as "high risk," which is the highest in its report, for 15 total care areas: pharmacy/medication management, nutrition/hydration, skin wound/pressure ulcer, complex care management, incident risk management/ADLs, infection control, change of condition, MDS assessments, care planning, elopement risk, behavior/dementia/trauma management, pain management, bowel/bladder, QAPI and medical records. A true and correct copy of the 2020 Polaris Report (TheVillagesofOrleans_028878-905) is attached hereto as **Exhibit 43**.

131. Per the 2020 Polaris Report, a score of "high risk" indicates a "pattern of breakdown in implementation with or without negative outcome." (Ex. 43 at 2.)

132. The Polaris consultant was unable to assess The Villages in the category of "Abuse Reporting/Dignity" and assigned a finding of "NA" in this category because the new DON and Administrator could not "readily locate any recent reports or investigations." (*Id*. at 15.)

133. The Polaris consultant also assigned an "NA" score for The Villages in the Environmental/Emergency Controls category because The Villages did not have performance improvement plans or systems for high-risk areas. (*Id*. at 22.)

Respondents Maintained The Villages at Chronically Inadequate Staffing Levels.

134. As detailed below, based on Medicaid Cost Reports, Payroll-Based Journal data, timekeeping records for The Villages' staff, admission records, accident and incident reports, and other data sources, MFCU found significant evidence of the following: (1) The Villages heavily relied on third-party agency workers to provide direct-care to residents, and The Villages levels of employee turnover were exceptionally high; (2) The Villages provided residents with less than the New York State average hours of nursing care, and routinely failed to meet its own staffing requirements, while continuing to admit new residents in the run-up to COVID-19; and (3) residents of The Villages suffered repeat accidents and injuries in a short-time span.

Respondents Relied on Agency Staff as a Stopgap Measure.

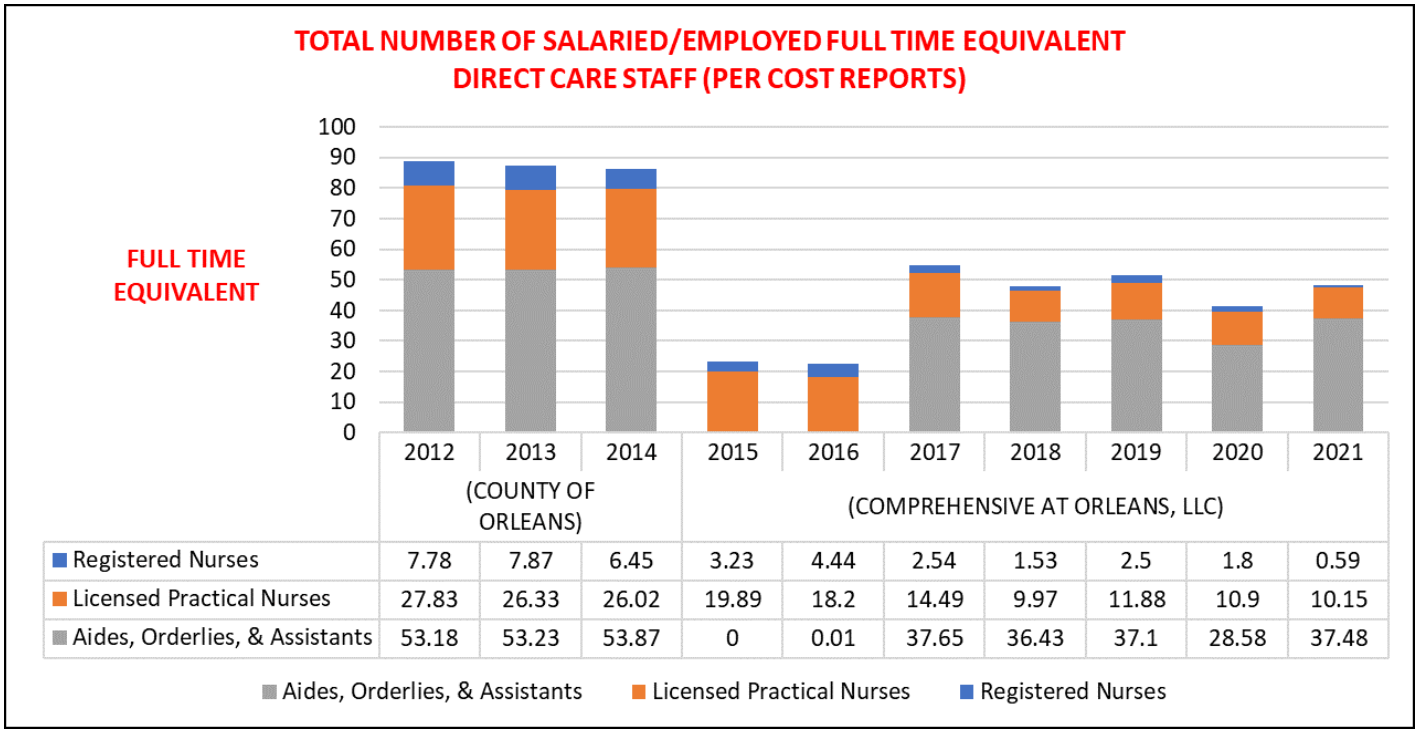
135. As part of this investigation, MFCU assessed the extent to which The Villages utilized short-term agency staff members as opposed to fulltime direct-care employees. This analysis was based on The Villages' Medicaid Cost Reports,[36] which delineate employee and agency staffing levels and expenditures, and are submitted to DOH on an annual basis.

136. The following chart depicts the number of Full Time Equivalent ("FTE") direct care[37] employed staff for the facility during the period 2012 to 2021, as reported on the facility's Medicaid Cost Reports (Schedule 5 – Full Time Equivalents & Hours Paid). As set forth below, during the period of Orleans County's ownership and operation (2012-2014), the facility

[36] Pursuant to 10 NYCRR § 86-2.2, nursing home providers are required to file complete and accurate annual financial and statistical reports ("Medicaid Cost Reports") to DOH. These reports include revenues, expenses, assets, liabilities, and statistical data. The data is used by DOH to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends. True and correct copies of Schedules 4, 5, 7, 9, P, and Exhibit H (and, as to 2020 only, Part III(1)) from The Villages Medicaid Cost Reports for years 2015-2021 are attached hereto as **Exhibits 59-65**.

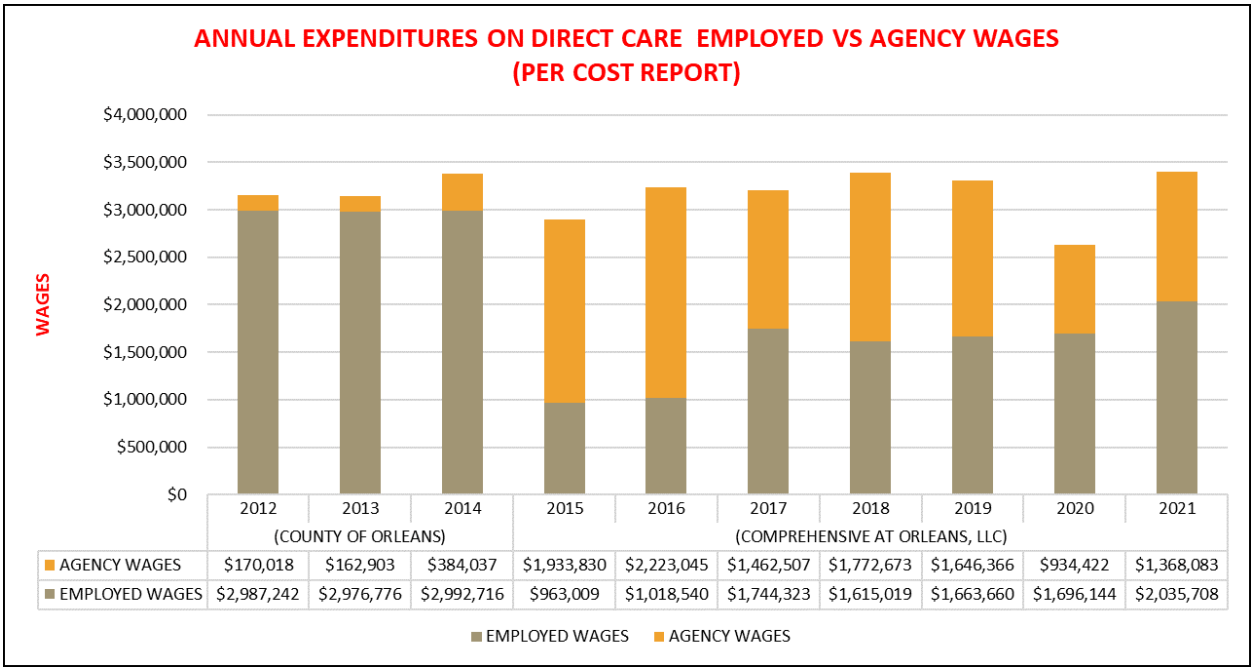
[37] Direct care staff are considered to be the RNs, LPNs and CNAs who provide the necessary medical and clinical services to residents. (*See* 10 NYCRR § 415.13[a].)

employed, on average, 7.37 FTE RNs, 26.73 FTE LPNs, and 53.43 FTE Aides, Orderlies, and Assistants. On the other hand, during the period of Respondents' ownership and operation from 2015 to 2021, The Villages employed, on average, 2.38 FTE RNs, 13.64 FTE LPNs, and 25.32 FTE Aides, Orderlies, and Assistants. This decrease represents an approximately 68% drop in FTE RN employees, a 49% drop in FTE LPN employees, and a 53% drop in FTE Aide, Orderly, and Assistant employees.



137. Similarly, the following chart depicts the facility's annual expenditures for direct care employed staff as opposed to direct care agency staff for the period 2012 to 2021, as reported on Medicaid Cost Reports (Schedule 4 – Salaries & Wages; Exhibit H – Statement of Functional Expenses). Agency staffing averaged 7.31% of total annual direct care staff wages during the period of time up and until 2015 when the facility was owned and operated by Orleans County.

On the other hand, from January 2015 forward, agency staff averaged over 51% of total annual direct care staff wages.



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
	(COUNTY OF ORLEANS)			(COMPREHENSIVE AT ORLEANS, LLC)						
AGENCY WAGES	$170,018	$162,903	$384,037	$1,933,830	$2,223,045	$1,462,507	$1,772,673	$1,646,366	$934,422	$1,368,083
EMPLOYED WAGES	$2,987,242	$2,976,776	$2,992,716	$963,009	$1,018,540	$1,744,323	$1,615,019	$1,663,660	$1,696,144	$2,035,708

The Villages Churned Through Employees.

138. As part of this investigation, MFCU analyzed personnel data contained in Medicaid Cost Reports to measure annual turnover rates for employees at 24 low-performing nursing home facilities in New York State, including The Villages. MFCU found that The Villages had the highest employee turnover rate in 2019 and 2020 out of all 24 facilities measured.

139. Specifically, MFCU's analysis was based on data reported on Medicaid Cost Report Schedule P (Staff Turnover). Pursuant to this analysis, MFCU found that The Villages had annual employee turnover rates of 56.07% in 2018, 182.14% in 2019, 220.95% in 2020, and 296.84% in 2021. Moreover, these numbers do not include agency staff who are by their nature temporary and therefore fail to fully account for direct-care worker turnover as experienced by residents.

140. According to CMS' analysis, "as the average staff turnover decreases, the overall star ratings for facilities increases, suggesting that lower turnover is associated with higher overall quality."[38] Additionally, "[f]acilities with lower nurse turnover may have more staff that are familiar with each resident's condition and may be more able to identify a resident's change in condition sooner. The facility may be able to implement a plan to avoid an adverse event, such as a fall, for a patient."[39]

The Villages Staffed at Below-Average Nursing HPRD.

141. During the course of the investigation, MFCU reviewed Payroll-Based Journal ("PBJ") data for The Villages and all other New York State nursing homes that participate in the Medicaid or Medicare Programs for the period 2017-2021. PBJ data, which is publicly available for download on CMS' website,[40] reflects the hours nurse staff are paid to work each day. Skilled nursing facilities such as The Villages are required to submit this information to CMS on a quarterly basis.

142. PBJ data and similar staffing metrics are often quantified in terms of "hours per resident day" or "HPRD." Hours per resident day or HPRD refers to the hours of daily care that staff members provide to each resident of the nursing home. This measure is calculated by adding up the total number of hours worked by nursing staff and dividing it by the number of resident-days during the reporting period. MFCU calculated the average HPRD for nursing homes in New

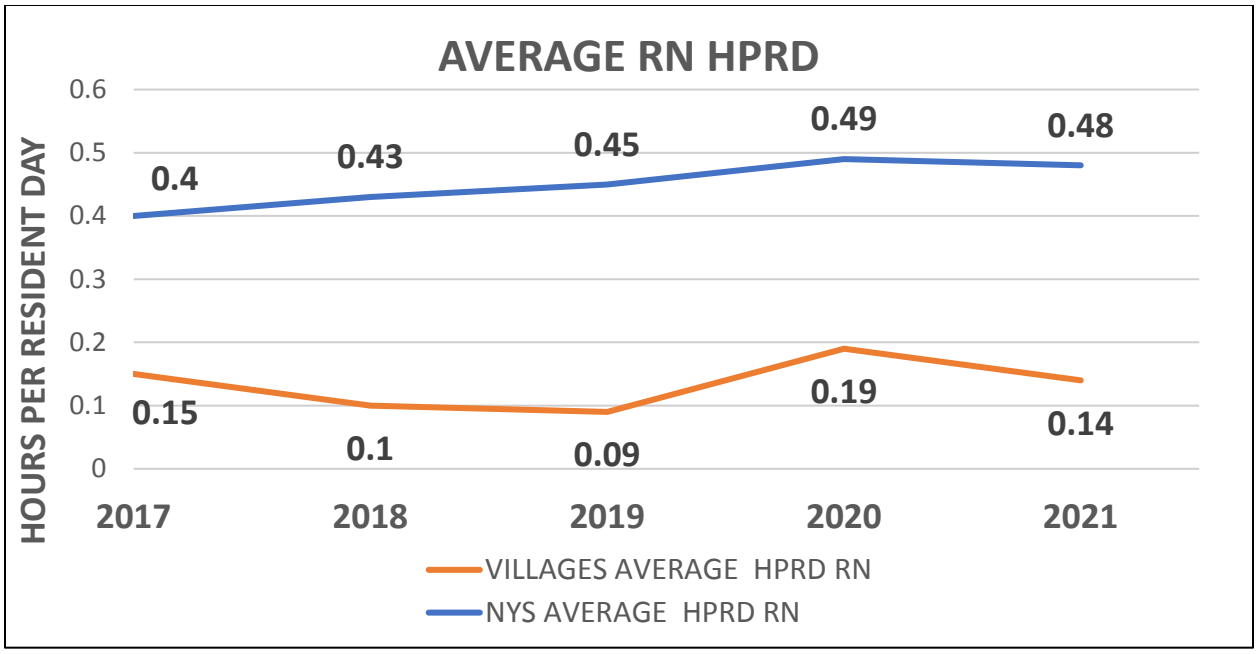
[38] CMS, *To Advance Information on Quality of Care, CMS Makes Nursing Home Staffing Data Available* (Jan. 26, 2022), available at https://www.cms.gov/newsroom/press-releases/advance-information-quality-care-cms-makes-nursing-home-staffing-data-available [last accessed Oct. 11, 2022].
[39] *Id*.
[40] *See* CMS, Payroll Based Journal Daily Nurse Staffing, https://data.cms.gov/quality-of-care/payroll-based-journal-daily-nurse-staffing (last accessed Oct. 11, 2022).

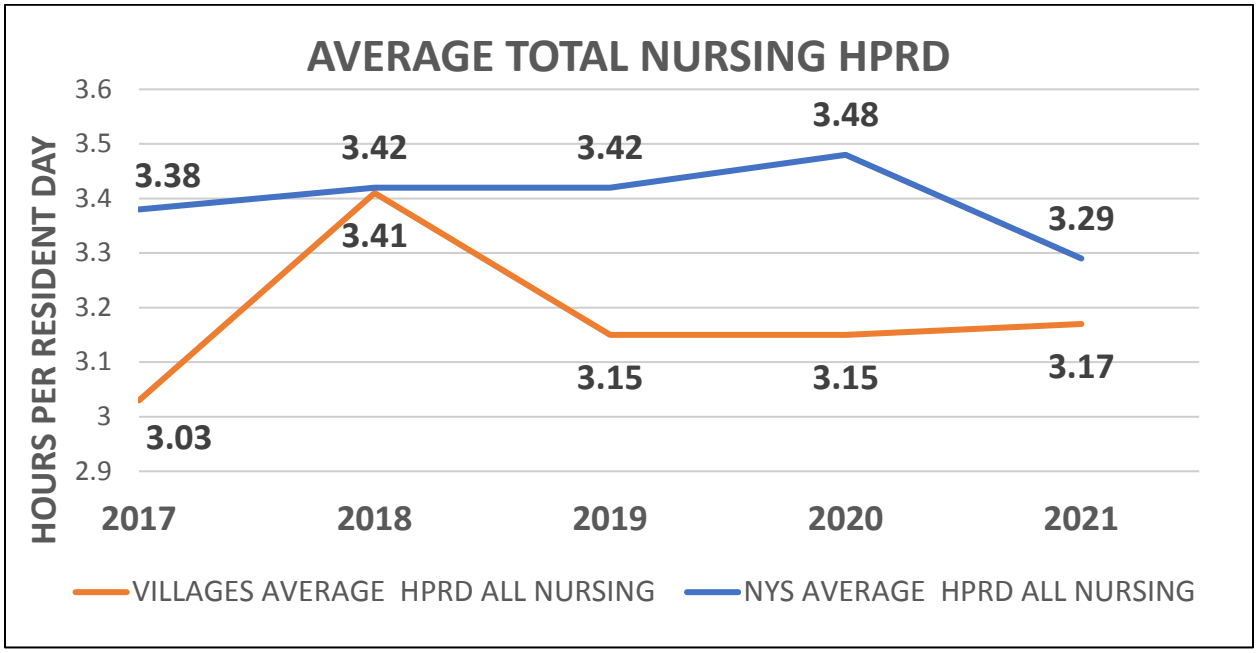
York State for the staffing levels of (1) Registered Nurses ("RN HPRD") and (2) Total Nursing Care staff (including RNs, LPNs, and CNAs) ("Total Nursing Care HPRD").

143. For the period 2017 to 2021, The Villages had an average of 0.13 RN HPRD; and an average of 3.18 HPRD for Total Nursing Care (RN, LPN, CNA). According to MFCU's analysis of PBJ data for all nursing home facilities in New York State, the New York State average during the same period was 0.45 RN HPRD and 3.40 Total Nursing Care HPRD. In other words, The Villages' average RN HPRD (0.13) was approximately 71% below the state average (0.45) and The Villages' Total Nursing Care HPRD (3.18) was approximately 6% below the state average (3.40).

144. Additionally, according to MFCU's analysis of PBJ data for all nursing home facilities in counties surrounding Orleans County (Niagara, Genesee, and Monroe), the average for 27 facilities during the same period was 0.34 RN HPRD. In other words, The Villages' average RN HPRD (0.13) was approximately 62% below the average of the 27 surrounding facilities (0.34).

145. The charts below show that The Villages' average RN HPRD and Total Nursing Care HPRD were consistently and significantly below the New York State average for each year during the period 2017 to 2021.





146. As detailed in the Medical Analyst Affidavit, nursing homes must ensure that there is adequate RN supervision on the individual units to ensure that its staff are being attentive to and timely performing their assigned duties and providing care that complies with the residents' care plans. Staff who work under insufficient supervision too often, for the sake of expediency, provide care negligently, in violation of residents' care plans. RN supervision is essential on all units on

all shifts, as licensed practical nurses cannot perform health assessments or other duties outside of their scope of practice. (*See* Medical Analyst Aff. ¶ 138.)

147. Recognizing the dire outcomes suffered by nursing home residents as a result of historically low staffing levels in for-profit nursing homes, New York State recently passed legislation (effective date April 1, 2022) which requires nursing homes to provide a minimum total of 3.5 HPRD. (*See* PHL § 2895-b.) The legislation further requires that of the 3.5 HPRD minimum, 2.2 hours should be provided by nursing aides and 1.1 hours should be provided by licensed staff (*i.e.*, RNs or LPNs). (*Id.*) This new law, even though just recently enacted, nonetheless provides a useful benchmark against which to assess The Villages' failure to historically attain even minimal staffing levels designed to ensure the well-being and care of its residents.[41]

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[41] In 2001, CMS released a landmark report on nursing home staffing based on a study mandated by Congress. The CMS study entitled "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes" concluded that there was "strong evidence" that "supports the relationship between increases in nurse staffing ratios and avoidance of critical quality of care problems." (Marvin Feuerberg, *Centers for Medicare & Medicaid Services (CMS) Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report* [Dec. 2001], available at https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf [last accessed Oct. 17, 2022.]) While the 2001 CMS report stopped short of making specific policy recommendations, the 2001 CMS study identified 4.1 hours of total direct care nursing time for long-stay populations, expressed in terms of nursing hours per resident day, as the staffing threshold "below which quality of care was compromised." (*Id.*) CMS noted that the closer a nursing home gets to 4.1 HPRD (2.8 HPRD from CNAs and 1.3 HPRD for licensed nursing staff, specifically including .75 HPRD from RNs), the greater the improvements in quality care. (*Id.*)

That analysis has since been validated by further research, and a number of researchers and nursing organizations have endorsed 4.1 HPRD as the minimum staffing level for nursing homes to improve resident outcomes in terms of fewer pressure ulcers, lower restraint use, decreased infections, lower pain, improved activities of daily living, less weight loss, dehydration, less improper and overuse of antipsychotics, lower mortality rates, reduced emergency room use, and rehospitalizations. (*See* Charlene Harrington, *et al.*, *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, Health Serv. Insights [June 2020], available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/#:~:text=A%20CMS%20study%20in%202001,harm%20or%20jeopardy%20to%20residents [last accessed Oct. 7, 2022] [*citing* American Nurses' Association ("ANA"), *Nursing Staffing Requirements to Meet the Demands of*

The Villages Provided Fewer Staff than Required but Continued to Admit New Residents.

148. Pursuant to 42 CFR 483.70(e), "[t]he facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually."

149. During the course of the investigation, The Villages produced a "Facility Assessment Tool" (last updated March 1, 2020) ("Facility Assessment Tool"), which lists the level of staff required to care for the residents on a per shift basis. A true and correct copy of the Facility Assessment Tool (VillagesOfOrleans_103327-337) is attached hereto as **Exhibit 45**. Versions of this assessment tool date back to at least 2017. MFCU compared the Facility Assessment Tool against actual staff shift data, or "punch card" data, and found that The Villages routinely failed to meet its own required staffing levels.

Today's Long Term Care Consumer, Recommendations from the Coalition of Geriatric Nursing Organizations (CGNO), Position Statement Endorsed by ANA, available at https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-staffing-requirements-to-meet-the-demands-of-todays-long-term-care-consumer/ [last accessed Oct. 7, 2022]). Harrington and the ANA also support even higher staffing standards for residents with higher acuity.

Even though the Harrington study was published early in the pandemic, Harrington noted that "[d]uring the coronavirus pandemic in 2020, the importance of adequate nursing home staffing [had] become even more critical in protecting the health and safety of residents." (*citing* Farah Stockman, Matt Richtel, Danielle Ivory, and Mitch Smith, *They're Death Pits: Virus Claims at Least 7,000 Lives in U.S. Nursing Homes*, NYTimes, Apr. 17, 2020, available at https://www.nytimes.com/2020/04/17/us/coronavirus-nursing-homes.html [last accessed Oct. 7, 2022]; Jordan Rau and Anna Almendrala, *COVID-plagued California Nursing Home Often Had Problems in Past*, Kaiser Health News. May 4, 2020, available at https://khn.org/news/covid-plagued-california-nursing-homes-often-had-problems-in-past/ [last accessed Oct. 7, 2022]; Anna Wilde Mathews, Andrea Fuller and Joseph De Avila, *Thinly-staffed Nursing Homes Face Challenges in Pandemic*, Wall Street Journal, May 1, 2020, available at https://www.wsj.com/articles/thinly-staffed-nursing-homes-face-challenges-in-pandemic-11588343407 [last accessed Oct. 7, 2022]).

150. Specifically, the Facility Assessment Tool includes a table (Table 7) labeled "Staffing Plans" which states that the table reflects an "[e]valuation of necessary facility direct care providers to ensure residents needs are practicably met." This table further includes sections delineating the required LPN to resident staffing ratio and the CNA to resident staffing ratio.[42] (Ex. 45 at 7.)

151. As to LPNs, based on an average resident census of 115, the Facility Assessment Tool provides that the "[t]otal number needed" of LPNs daily is five for day and evening shifts and four for night shifts. This means that The Villages assessed itself as needing approximately one LPN for every 23 residents for day and evening shifts (115 residents to 5 LPNs), and approximately one LPN for every 29 residents during night shifts (115 residents to 4 LPNs). (*Id*.)

152. As to CNAs, the Facility Assessment Tool provides that the "total number needed" of CNAs daily is 10 for day and evening shifts and six for night shifts. This means that The Villages assessed itself as needing approximately one CNA per 12 residents for day and evening shifts (115 residents to 10 CNAs), and approximately one CNA per 19 residents for night shifts (115 residents to 6 CNAs).[43] (*Id*.)

[42] Other evidence reinforces the importance of the Facility Assessment Tool. For example, The Villages of Orleans Health and Rehabilitation Center Staffing Policy ("Staffing Policy"), dated March 10, 2020, states "[t]he facility shall confirm prior to holidays and if necessary, weekends, the front line (specifically clinical teams) staffing schedule is appropriately staffed *in accordance with the facility assessment tool* and the NYS DOH guidelines." (emphasis added.) A true and correct copy of the Staffing Policy (VillagesOfOrleans_000832) is attached hereto as **Exhibit 46.**

[43] The Villages updated the Facility Assessment Tool again on March 17, 2021 ("March 2021 Facility Assessment Tool"). Although not the basis for MFCU's analysis, this later version of the tool requires even higher staffing levels for competent care. Specifically, the March 2021 Facility Assessment provides that The Villages will staff six LPNs for day and evening shifts (approximately 16 residents/ LPN), four LPNs for night shifts (approximately 24 residents/ LPN), 12-13 CNAs for day and evening shifts (approximately 8 residents/ CNA), and 7 CNAs for night shifts (approximately 14 residents/ CNA). A true and correct copy of the March 2021 Facility Assessment is attached hereto as **Exhibit 47**.

153. The Facility Assessment Tool further reflects that The Villages' high-level managers reviewed and updated the assessment on an annual basis during the period 2017 to 2020, and The Villages' QAPI committee reviewed the assessment on an annual basis (2018 to 2020). (*Id*. at 1.)

154. MFCU analyzed The Villages' staff "punch cards" and resident census records for the period January 1, 2020, to June 11, 2020,[44] and compared the staff to resident ratios reflected in those records to the Facility Assessment Tool staffing ratios.

155. As to CNA staffing, MFCU found that approximately 223 out of 489 total CNA shifts (46%) were below the assessment ratio. As to nurse staffing, MFCU found that approximately 184 out of 489 total nurse shifts (38%) were below the assessment ratio.

156. MFCU further found that The Villages continued to admit new residents despite this chronic understaffing. MFCU obtained resident admission records and reviewed the frequency with which The Villages admitted new residents during months in which staffing fell below the assessment ratio in analysis period January 1, 2020, to June 11, 2020. This analysis shows that The Villages consistently admitted new residents during months in which staffing fell below the requisite level in the run up to COVID-19.

157. The chart below depicts (a) new resident admissions for each month during the period January 1, 2020, to June 11, 2020 ("Number of New Resident Admissions to Villages"); and (b) the percentage of total shifts below the Facility Assessment Tool level for nurse and CNA positions (% of Shifts below Level).

[44] MFCU's analysis was limited to the period January 1, 2020 to June 11, 2020 because this is the period for which data was readily available.

Month of Admission	Number of New Resident Admissions to The Villages	POSITION	% of Monthly Shifts below Level
JANUARY 2020	14	CNA	33%
		NURSE	20%
FEBRUARY 2020	12	CNA	45%
		NURSE	43%
MARCH 2020	18	CNA	57%
		NURSE	46%
APRIL 2020	2	CNA	67%
		NURSE	49%
MAY 2020	0	CNA	34%
		NURSE	28%
JUNE 2020 (6/1-6/11)	3	CNA	24%
		NURSE	45%

Residents of The Villages Suffered Repeat Accidents and Incidents.

158. New York State regulations mandate that nursing homes create and maintain accident and incident records, including "a clear description of every accident and any other incident involving behavior of a resident or staff member that poses a threat to a resident or staff member, the resident's version of the accident or incident unless the resident objects or is unable to give a report due to his/her medical condition, names of individuals involved and a description of medical and other services provided, by whom such are provided, and the steps taken to prevent recurrence." (10 NYCRR § 415.30[f].)

159. As detailed in the Medical Analyst Affidavit, accidents and incidents are more frequent in nursing homes with insufficient staffing. Among other things, insufficient staffing to timely answer call bells when residents need to use the toilet leads to increased risk of falls. When

staff do not respond timely, or at all, residents are more likely to try to stand up, or get out of bed, and walk or otherwise move to the bathroom by themselves. Insufficient staff also increases the risk of falls and injury because it causes staff to provide improper care to residents, such as one aide alone transferring a resident from their bed to a wheelchair despite the resident's care plan requiring the assistance of two caregivers. Further, insufficient supervisory staff to oversee staff performing their job duties often results in resident neglect and mistreatment by direct care staff who fail to provide required care to residents, either due to inadequate or poor training, inattentiveness, or because staff is simply left to do too much due to lack of support from other staff. (*See* Medical Analyst Aff. ¶¶ 143-145.)

160. MFCU's review of accident and incident reports produced by The Villages identified approximately 39 accidents and incidents at The Villages in January 2020. Approximately five residents were involved in multiple incidents in that month. For example, Resident 49[45] fell off his bed on January 6, and The Villages' staff found Resident 49 on the floor on three separate occasions on January 8, 9, and 10. Nursing notes reflect that Resident 49 suffered a hematoma in connection with the January 10 fall. As shown above, in January 2020, 33% of CNA shifts and 20% of nurse shifts at The Villages were below the Facility Assessment Tool level.

161. MFCU identified approximately 40 accidents and incidents in February 2020. Approximately 11 residents were involved in multiple incidents in that month. For example, Resident 58 fell on February 18, 19, and 23, and The Villages' staff found Resident 58 on the

[45] To shield protected health information, Residents are referenced herein by numerical identifiers, rather than names. Residents' numerical identifiers are consistent throughout Petitioner's papers.

bathroom floor on February 11 and 20. As shown above, 45% of CNA shifts and 43% of nurse shifts at The Villages were below the Facility Assessment Tool level in February 2020.

162. MFCU identified approximately 49 accidents and incidents in March 2020. Approximately nine residents were involved in multiple incidents in that month. For example, Resident 19 fell on [redacted], and The Villages' staff found him on the floor on three separate occasions on [redacted]. Nursing notes reflect that Resident 19 suffered a bleeding head injury on [redacted]. As shown above, in March 2020, 57% of CNA shifts and 46% of nurse shifts at The Villages were below the Facility Assessment Tool level.

163. MFCU identified approximately 48 accidents and incidents in April 2020. Approximately nine residents were involved in multiple incidents that month, including Resident 19 (discussed above) who was involved in 10 separate incidents during the month. For example, The Villages' staff discovered Resident 19 on the floor seven times in April, including during the evening of [redacted] when The Villages' staff found Resident 19 on the floor of his room with feces smeared around him. Resident 19 further suffered two falls on [redacted], one of which resulted in a bleeding head injury. As shown above, in April 2020, 67% of CNA shifts and 49% of nurse shifts at The Villages were below the Facility Assessment Tool level.

164. MFCU identified approximately 43 accidents and incidents in May 2020. Approximately six residents were involved in multiple incidents that month. For example, Resident 19 (discussed above) fell or was found on the floor on 13 separate occasions in May 2020. Also in May 2020, Resident 59 fell in the bathroom on three separate occasions, including on May 23 and 25 when Resident 59 suffered head lacerations. As shown above, in May 2020, 34% of CNA shifts and 28% of nurse shifts at The Villages were below the Facility Assessment Tool level.

DOH Surveyors Issued Numerous Citations to The Villages for Recurrent Building Code Deficiencies.

165. In an annual survey completed on April 25, 2016, DOH surveyors observed numerous safety code violations, including:

- Building's fire alarm system was not properly maintained. Issues included audio/ visual signal devices, visual only signal devices, and electromagnetic releasing devices that were not tested on an annual basis; and
- Items were stored directly below and less than 18 inches away from sprinkler heads, quarterly inspecting and testing was not conducted on the building's automatic sprinkler system, and corroded and damaged sprinkler heads had not been replaced.

(*See* Ex. 25.)

166. In an annual survey completed on July 12, 2017, DOH surveyors observed numerous safety code violations, including:

- Doors did not fully close and automatically latch;
- Set of cross corridor smoke barrier doors did not fully close when released;
- No record of testing of smoke and fire dampers; and
- The Villages did not properly maintain electrical equipment. Specifically, multiplug adaptors used in resident rooms were not properly listed for their use, and power strips and/or multiplug adaptors were used in a series (daisy chained).

(*See* Ex. 27.)

167. In an annual survey completed on November 16, 2018, DOH surveyors observed numerous code violations, including:

- Failure to perform a quarterly sprinkler inspection;
- Failure to test smoke and fire dampers;

- Failure to repair problems with the facility's generator; and
- Failure to inspect battery powered lifts on a monthly basis per manufacturer's guidelines.

(*See* Ex. 29.)

168. In an annual survey completed on September 14, 2020, DOH surveyors found numerous deficiencies, including:

- Fire barrier walls were not designed to have at least a two hour fire resistance rating due to the presence of a non-fire rated material;
- Doors equipped with delayed egress locks lacked signage with instruction explaining how the doors could be opened in an emergency;
- A stairway, that was used as an exit, was not properly maintained. The stairway door did not self-close and latch onto its door frame;
- Exit signs were not properly maintained;
- A corridor door protecting a hazardous area did not self-close and latch into its door frame;
- Sprinkler heads were coated with debris;
- Portable fire extinguishers were stored on the floor or were obstructed from immediate use;
- Doors protecting corridor openings were not properly maintained to resist the passage of smoke because corridor doors could not be latched closed into their door frames;

- Smoke barriers were not complete from floor to roof deck, not designed to have at least a 30-minute fire resistance rating, and not designed to be resistant to the passage of smoke;
- The facility did not conduct fire drills at least once, per shift, per quarter;
- Electrical junction boxes and electrical duplex outlets were missing their cover plates and light switch covers were cracked;
- The facility did not have documented evidence that the emergency generators were exercised under lead for at least 30 minutes on a monthly basis and were inspected on a weekly basis; and
- Extension cord and power strips were not properly maintained. In-use extension cords and power strips being used to supply power to various electrical devices were plugged into other power strips.

A true and correct copy of the Statement of Deficiencies, Exit Date September 14, 2020, is attached hereto as **Exhibit 48**.

169. In a survey completed on April 26, 2021, DOH surveyors found numerous deficiencies, some of which are the same as the year before:

- Smoke barriers were not complete from floor to roof deck, not designed to have at least a 30-minute fire resistance rating, and not designed to be resistant to the passage of smoke;
- Fire barrier walls were not designed to have at least a two-hour fire resistance rating due to the presence of a non-fire rated material;
- Multiple doors, including a corridor door protecting a hazardous area, did not self-close and latch into their door frames;

- Signage stating that oxygen was stored within a room was not present; and
- Fire dampers that failed inspection and testing were not repaired or replaced.

(*See* Ex. 40.)

170. In a survey completed on October 25, 2021, DOH surveyors found numerous deficiencies, some of which are the same as the year before:

- Facility turned off an air handling unit that supplied fresh air to the interior of the building and removed exhaust air from-the interior of the building;
- Excessive amounts of lint and dust in, on, and around the laundry room's clothes dryers and on the exterior of the building and ground outside of the laundry room;
- Smoke barriers were not complete from floor to roof deck, not designed to have at least a 30-minute fire resistance rating, and not designed to be resistant to the passage of smoke;
- A stairway door did not self-close and latch into its door frame;
- Doors were held open and obstructed from closing;
- A main sprinkler valve was leaking, and sprinkler heads were covered with dust and debris;
- Portable fire extinguishers were obstructed and not properly maintained;
- Fire dampers that failed inspection and testing were not repaired or replaced;
- Electrical wiring was not installed inside of electrical junction boxes and an electrical junction box was missing its cover plate;
- The facility's two emergency generators were not properly maintained; and

- Extension cord and power strips were not properly maintained. In-use extension cords and power strips being used to supply power to various electrical devices were plugged into other power strips.

(*See* Ex. 41.)

From January 2015 through June 2022, Respondents Siphoned Over $18.6 Million from The Villages, a Profit of Nearly 22% From a Primarily Government-Funded Facility.

Revenue as Reported on Medicaid Cost Reports

171. According to Medicaid Cost Reports (Schedule 7 – Analysis of Net Patient Revenue & Total Operating Revenue) for the time period 2015 through 2021, The Villages reported total Medicaid net revenue of $48,672,539.

172. According to Medicaid Cost Reports (Schedule 7 – Analysis of Net Patient Revenue & Total Operating Revenue) for the time period 2015 through 2021, The Villages reported total Medicare net revenue of $10,578,890.

173. According to Medicaid Cost Reports (Schedule 7 – Analysis of Net Patient Revenue & Total Operating Revenue) for the time period 2015 through 2021, The Villages reported total private patient revenue of $16,991,683.

Revenue as Evidenced by Bank Analysis

174. According to bank analysis, during the period January 1, 2015, through June 30, 2022, the New York State Medicaid Program paid approximately $28,641,927 to The Villages via EFTs to Villages 2408.

175. During the same period, managed care organizations and other insurers paid approximately $7,724,702 to The Villages via EFTs to Villages 2408.

176. During the same period, the Medicare Program paid approximately $8,802,067 to The Villages via EFTs to Villages 2408.

177. During the same period, The Villages transferred approximately $32,625,000 from Villages 5897 into Villages 2408. These funds were comprised of private pay and Medicaid recipient contributions towards the cost of care calculated based on Net Available Monthly Income (NAMI).

178. According to bank analysis and remarks reflected on bank statements, during the period May 2020 through February 2022, approximately $1,189,556 was credited to Villages 2408. Remarks associated with these transfers were "US HHS Stimulus Payments" and "HRSA Provider."

Respondents Paid "Rent" to Themselves.

179. Based on remarks associated with internal bank transfers and reflected on bank statements, during the period January 1, 2015, through June 30, 2022, The Villages (Villages 2408) transferred approximately $15,750,360 in funds identified as purported "rent" payments to Telegraph (Telegraph 3849). Remarks associated with these transfers included "Rent for distributions," "Monthly Rent," and "Distributions recorded as rent." Specifically, bank analysis reflects that The Villages transferred approximately $880,000 in purported "rent" payments to Telegraph in 2015; $2,268,000 in 2016; $2,890,000 in 2017; $1,514,000 in 2018; $2,454,070 in 2019; $1,734,290 in 2020; and $3,440,000 in 2021.[46] Moreover, The Villages' "rent" payments do not include property taxes, insurance, and maintenance costs, which The Villages was obligated to pay separately and apart from "rent" pursuant to its first and its operative lease agreements with Telegraph.[47] A true and correct copy of The Villages' First Lease Agreement with Telegraph is

[46] MFCU identified $2.3 million of the $3.44 million Respondents transferred in 2021 as purported "rent" payments based on the pattern of Respondents' financial dealings, rather than remarks associated with bank transfers.

[47] As explained below, The Villages entered into two lease agreements with Telegraph. DOH relied on the first lease agreement in approving The Villages' Certificate of Need application in

attached hereto as **Exhibit 49**. A true and correct copy of The Villages' Operative Lease Agreement with Telegraph (VillagesOfOrleans_0000501-520) is attached hereto as **Exhibit 50**.

180. In addition to monthly rent payments, to satisfy The Villages' obligation to pay Telegraph "profits of up to One Million ($1,000,000) Dollars per annum" pursuant to the Operative Lease Agreement, The Villages (Villages 2408) transferred $67,910 to Telegraph (Telegraph 3849) in April 2020 and $249,930 in May 2020. This time period mirrors the first wave of the COVID-19 pandemic in the United States and an outbreak in the facility in early 2020.

181. According to MFCU's analysis of rent to revenue ratios based on data reported on 2020 Medicaid Cost Reports (Schedule 7 – Analysis of Net Patient Revenue & Total Operating Revenue; Schedule 9 – Property Expenses) for nursing home facilities in New York State, the average rent to revenue ratio for for-profit nursing home facilities in New York State was 10.62%. Per The Villages' 2020 Medicaid Cost Report, The Villages' 2020 rent to revenue ratio was 23.8%, approximately 124.1% greater than the state average.

182. According to MFCU's analysis of Medicaid Cost Report data (Schedule 9 – Property Expenses) for nursing home facilities in New York State, in 2018, The Villages had the highest rent to revenue ratio out of 24 nursing home facilities in the Finger Lakes economic region.[48] Per the same analysis, The Villages paid the highest rent plus property taxes per square foot in the Finger Lakes economic region.

2014. By contrast, the operative lease agreement provides for additional payments from The Villages to Telegraph of up to $1,000,000 per annum. Neither the first nor the operative agreement is dated – however, evidence shows that The Villages submitted the first lease to DOH in connection with licensure but followed the operative lease agreement in practice. (*See* ¶¶ 216-219, *infra*.)

[48] The Finger Lakes economic region includes Genesee, Livingston, Monroe, Orleans, Ontario, Seneca, Wayne, Wyoming, and Yates counties.

183. Based on remarks associated with internal bank transfers and reflected on bank statements, and based on observation of Respondents' financial transactions, during the period January 1, 2015, through June 30, 2022, Telegraph (Telegraph 3849) transferred $9,826,936 to the Individual Respondents, as further detailed below.[49] Remarks included "Orleans Salary" and "Telegraph Monthly Distribution."

TELEGRAPH "RENT" DISTRIBUTIONS	
RECIPIENT	**AMOUNT**
Fuchs, Bernard	$323,266
Edelstein, Joel	$323,266
Freund, Israel	$331,599
Fuchs, Gerald	$323,266
Fuchs, Tova	$323,266
Gast, David	$2,276,648
Halper, Sam	$919,229
Lahasky, Ephram	$1,716,967
Landa, Ben	$833,625
Farkovits, Joshua	$843,625
Lichtschein, Teresa	$760,598
Korngut, Debbie	$851,582
TOTAL	**$9,826,936**

[49] For purposes of cash flow analysis, payments to Gast LLC are treated as payments to Respondent **David Gast**. Additionally, over $1.5 million in payments from Telegraph to Lahasky LLC are treated as payments to Respondent **Ephram Lahasky**. Finally, payments made to a trust associated with **Sam Halper**, PA2 Grantor Trust, are treated as payments to Respondent **Halper**. Remarks associated with transfers to PA2 Grantor Trust include "Sam H. Tel. Distr." In December 2020, Respondent **Halper** transferred approximately $3,000,000 from his personal bank account at JP Morgan Chase Bank, account ending 0751, to PA2 Grantor Trust.

Respondents Saddled The Facility with Debt.

184. In January 2015, The Villages and Telegraph obtained a $6,300,000 mortgage loan from The Private Bank to finance the $7,800,000 purchase of the real property and business assets from OCHFC.

185. In January 2017, Telegraph obtained a $15,000,000 loan from The Private Bank to refinance the original mortgage. The bank's appraisal in connection with the loan application reflects a $14,400,000 valuation of the facility and real property. (*See* Ex. 17 at 9.)

186. On or around January 30, 2017, at the direction of **Ephram Lahasky**, the title company associated with the refinancing (Riverside Abstract LLC) wired approximately $4,106,242 in loan proceeds to Telegraph (Telegraph 3849). On or around January 31, 2017, Telegraph paid approximately $4,394,338 to the Individual Respondents, as further detailed below.

REFINANCE PROCEEDS DISTRIBUTION	
RECIPIENT	**AMOUNT**
Fuchs, Bernard	$146,478
Edelstein, Joel	$146,478
Freund, Israel	$146,478
Fuchs, Gerald	$146,478
Fuchs, Tova	$146,478
Gast, David	$922,664
Halper, Sam	$542,115
Lahasky, Ephram	$732,390
Landa, Ben	$366,195
Farkovits, Joshua	$366,195
Lichtschein, Teresa	$329,575
Korngut, Debbie	$402,814
TOTAL	**$4,394,338**

186. MFCU's investigation found no evidence that any of the Individual Respondents reinvested any of these loan proceeds to improve the building, operations or quality of life and care for residents at The Villages. Additionally, by making The Villages responsible for debt service, The Villages paid down the mortgage and therefore Respondents accrued equity in the real estate.

187. In addition, per the terms of the 2017 refinancing, the title company transferred $3,700,000 in loan proceeds to a collateral-blocked account in the name of The Villages for the duration of the loan.

188. In December 2020, Telegraph refinanced the facility and the real estate with the U.S. Department of Housing and Urban Development ("HUD") via a subcontractor, Housing and Healthcare Finance, LLC, for the total sum of $14,541,000.

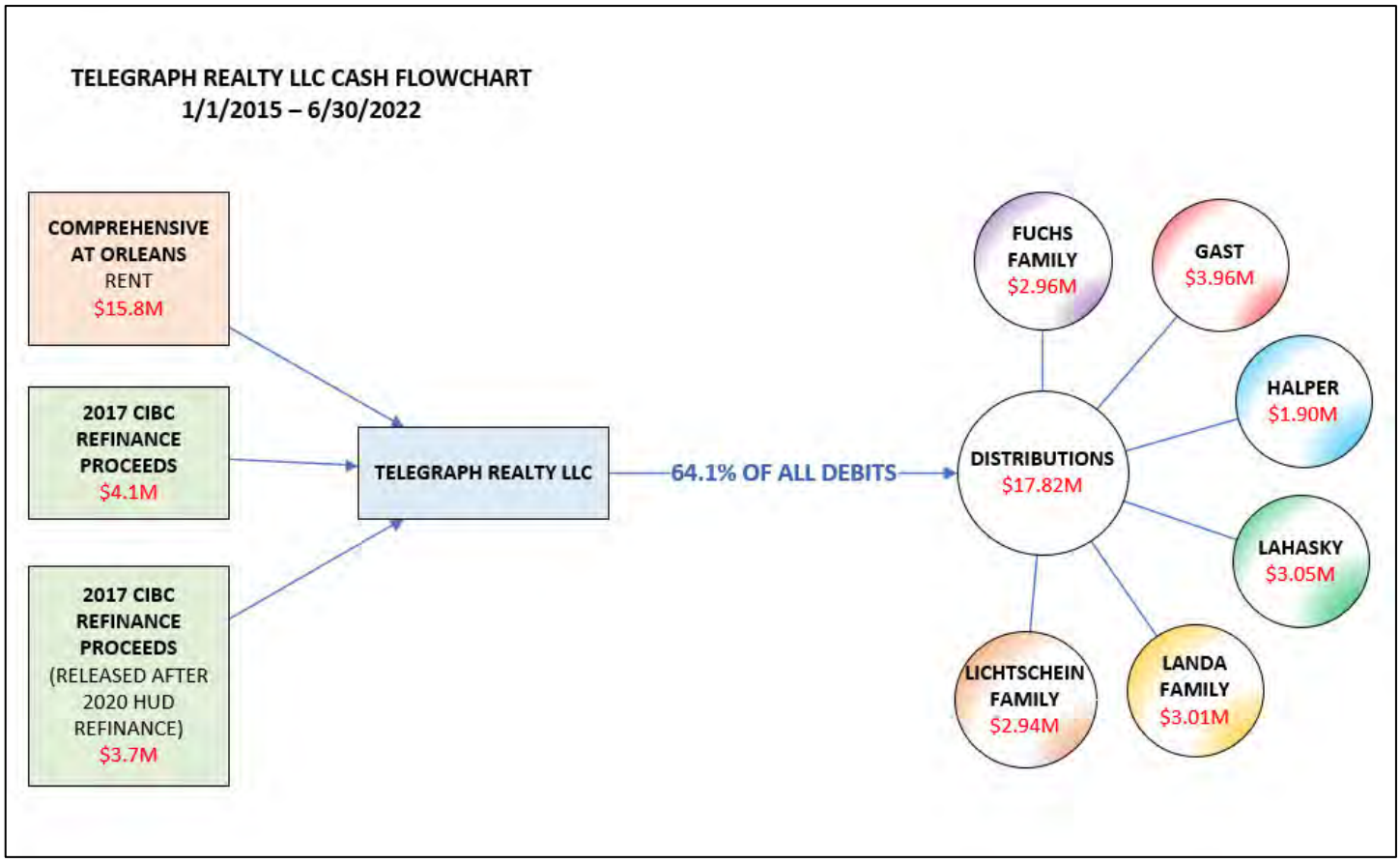
189. The refinancing closed on December 11, 2020. The day of the HUD closing, Respondents released $3,700,000 plus accrued interest from the collateral-blocked account and transferred it to Telegraph (Telegraph 3849).

190. Based on bank records and remarks associated with internal bank transfers and reflected on the bank statements, within one day, Telegraph (Telegraph 3849) transferred $3,600,000 to the Individual Respondents, as further detailed below. Remarks included "HUD Distribution."

ADDITIONAL REFINANCE PROCEEDS DISTRIBUTION	
RECIPIENT	**AMOUNT**
Fuchs, Bernard	$120,000
Edelstein, Joel	$120,000
Freund, Israel	$120,000
Fuchs, Gerald	$120,000
Fuchs, Tova	$120,000
Gast, David	$755,868
Halper, Sam	$444,132
Lahasky, Ephram	$600,000
Landa, Ben	$300,000
Farkovits, Joshua	$300,000
Lichtschein, Teresa	$270,000
Korngut, Debbie	$330,000
TOTAL	**$3,600,000**

191. MFCU's investigation found no evidence that any of the Individual Respondents reinvested any of these loan proceeds to improve the building, operations or quality of life and care for residents at The Villages.

192. The following chart depicts purported "rent" and mortgage loan proceeds paid into Telegraph and subsequently distributed to the Individual Respondents, as explained herein.



Respondents Paid Themselves "Management Fees" from CHMS Group and "Salaries" Directly from The Villages.

193. Per review of The Villages' bank records and based on remarks associated with internal bank transfers and reflected on the bank statements, for the period January 1, 2015, to January 31, 2021, The Villages (Villages 2408) transferred approximately $1,534,856 to CHMS Group (CHMS 8819 & CHMS 3360) as purported management fees. Remarks included "ORL MGMT" and "CHMS management fees."

194. Per review of The Villages' bank records and based on remarks associated with internal bank transfers and reflected on the bank statements, for the period February 1, 2021, to June 30, 2022, The Villages (Villages 2408) transferred an additional approximately $306,663 to

CHMS Group (CHMS 8819) as purported management fees. Remarks included "CHMS management fees."

195. Based on bank records and remarks associated with internal bank transfers and reflected on the bank statements, $1,534,856 represents 6.57% of total deposits into CHMS 8819 and CHMS 3360 during the period January 1, 2015, to January 31, 2021.[50] Other deposits into CHMS 8819 and CHMS 3360 were made by other nursing home facilities owned and/or controlled by Individual Respondents.

196. Therefore, distributions to Individual Respondents attributable to The Villages during the period January 1, 2015, to January 31, 2021, were calculated as 6.57% of all distributions from CHMS Group to the Individual Respondents during the same period per the chart below.

DISTRIBUTIONS FROM CHMS GROUP		
RECIPIENT	**TOTAL DISTRIBUTIONS**	**DISTRIBUTIONS ATTRIBUTABLE TO THE VILLAGES**
Gast, David	$440,274	$28,932
Halper, Sam	$1,007,662	$66,214
Lahasky, Ephram	$328,973	$21,617
TOTAL	**$1,776,909**	**$116,761**

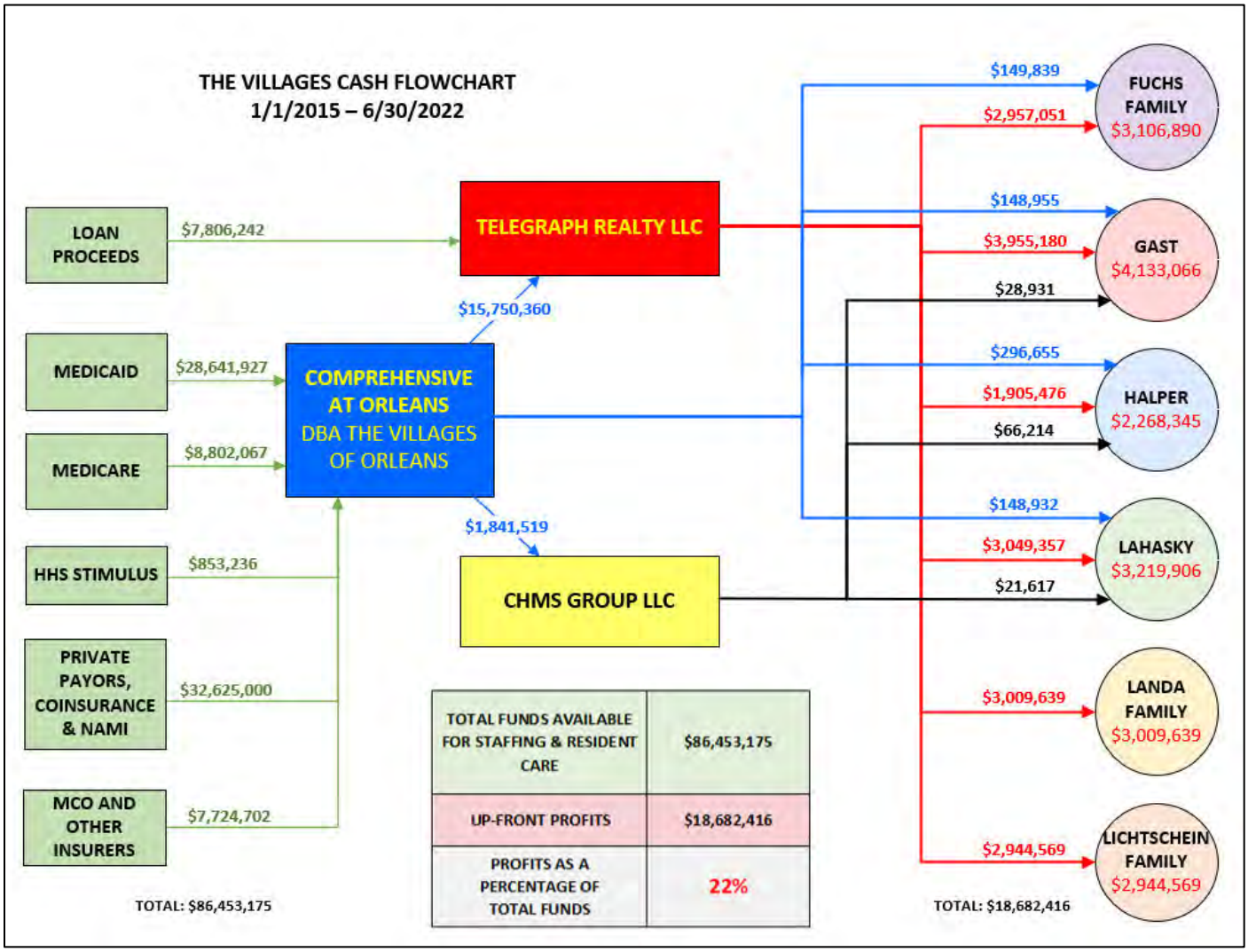
197. Additionally, based on remarks associated with internal bank transfers and reflected on bank statements, during the period January 1, 2015, through June 30, 2022, The Villages (Villages 2408) directly transferred approximately $744,380 to Respondents **Bernard Fuchs**, **David Gast**, **Sam Halper**, and **Ephram Lahasky**. Remarks associated with these transfers

[50] CHMS bank records for the period February 1, 2021, to June 30, 2022 are not available; therefore, MFCU calculated CHMS Group distributions to the Individual Respondents attributable to The Villages solely for the period January 1, 2015, to January 31, 2021.

included "Orleans salary" and "monthly salary." Specifically, The Villages paid **Bernard Fuchs** $149,839; **David Gast** $148,955; **Sam Halper** $296,655; and **Ephram Lahasky** $148,932.

The Payments to Respondents Total Over $18.6 Million.

198. As set forth above, during the period January 1, 2015, to June 30, 2022, the Individual Respondents collectively received over $18,600,000 in cash payments associated with The Villages. The following chart illustrates the amounts and sources of those payments.[51]

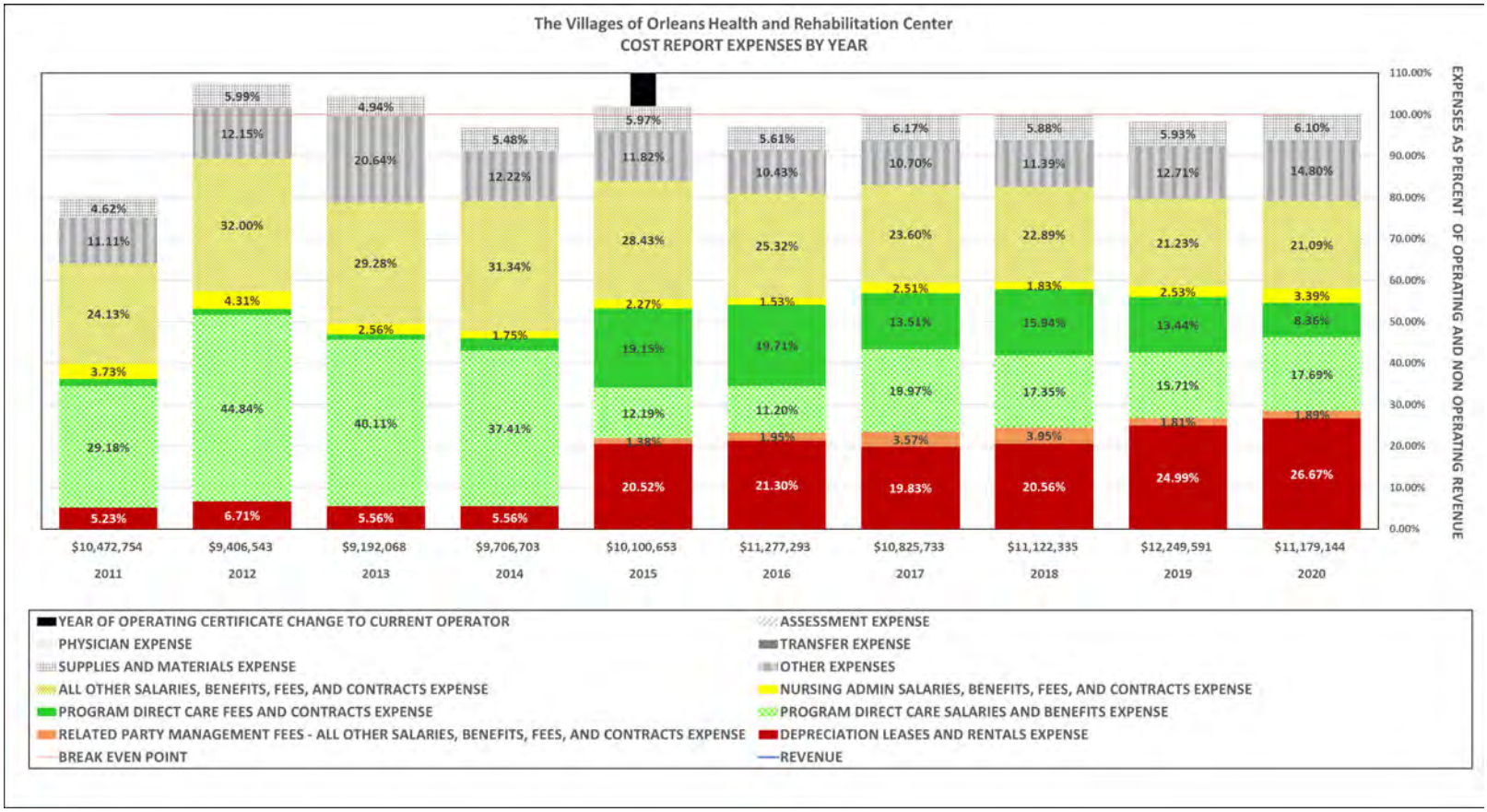


[51] As used in the above chart, "up-front profits" refers to cash payments to the Individual Respondents without corresponding investments to improve the building, operations or quality of life and care for residents at The Villages.

199. Of the over $18.6 million in total cash payments, the Individual Respondents received over $10,000,000 prior to 2020 and leading into the COVID-19 pandemic.

Respondents Encouraged a False Impression that Medicaid Rates Are Too Low to Enable Profit.

200. The chart below reflects that the Individual Respondents controlled The Villages' expenses, including through related party transactions, to ensure that its reported expenses and revenue netted out to almost even from 2015 through 2020. Specifically, The Villages reported small losses in 2015 (1.98%) and 2017 (.08%), small gains in 2016 (2.72%) and 2019 (1.65%), and no gain or loss in 2018 and 2020. Additionally, as shown below, during the period 2015 to 2020, The Villages reported that 22.09% of total expenditures, on average, were used for depreciation, leases, and rental expenses. As discussed, Telegraph paid millions in distributions to the Individual Respondents from these "rent" payments.



The Villages Failed to Obtain DOH Approval for Asset Transfers.

201. According to Medicaid Cost Reports (Schedule 9 – Property Expenses), The Villages reported $15,716,414 in rent expenses during the period 2015-2021.

202. PHL § 2808(5)(c) requires nursing home operators to obtain written permission from DOH prior to withdrawing equity or transferring assets in excess of 3% of a nursing home's annual revenue for patient care for the prior year. (*See* 10 NYCRR § 400.19 [defining "withdrawal" to include "any transfer of a facility's cash or other assets directly or indirectly for the benefit of its operator" and "any liability incurred . . . by a facility or its operator by reason of a mortgage, lease, borrowing or other transactions relating to such a facility that exceeds, in the aggregate, $50,000"].)

203. The chart below depicts: (a) The Villages' total operating revenue for the prior year (per Medicaid Cost Reports); (b) the monetary threshold triggering DOH approval for withdrawal or transfer (*i.e.*, 3% of the prior year's total operating revenue); and (c) the amount The Villages presented on Medicaid Cost Reports as rent obligations incurred to Telegraph Realty.

	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Prior Years Total Operating Revenue	x	$10,100,653	$11,277,293	$10,825,733	$11,122,335	$12,249,591	$11,179,144
3% of Total Operating Revenue	x	$303,020	$338,319	$324,772	$333,670	$367,488	$335,374
Transfer of Assets (Rent)	$1,852,506	$2,097,992	$1,813,432	$1,937,157	$2,680,000	$2,655,527	$2,680,000

204. Per DOH records, The Villages did not seek written permission from DOH for transfers of assets in excess of the 3% of the prior year's total operating revenue to Telegraph (or any other entity) at any time during the period 2015 to 2021.

205. Additionally, per DOH records, The Villages did not seek written permission from DOH for acquiring additional mortgage liability in excess of $50,000 in relation to either the 2017 refinance or the 2020 HUD refinance.

If the Individual Respondents Paid Themselves Just $360,000 Less in 2020, The Villages Could Have Provided 15,000 Additional Direct Care Hours.

206. As explained in paragraphs 188-91 above, the Individual Respondents paid themselves $3,600,000 in 2020 in connection with the HUD refinancing.

207. Based on data reported on The Villages' 2020 Medicaid Cost Report (including Schedules 4, 5, and 5(a)), if Respondents took $360,000 less that year (10% of loan proceeds), The Villages could have provided over 15,000 additional hours of direct care to residents during the COVID-19 pandemic. This includes RN, LPN, and CNA hours in proportion to the hours reported on the 2020 Medicaid Cost Report and based on the wage amounts therein. This analysis further incorporates payments for fringe benefits.

Respondents Made Affirmative Misrepresentations to DOH.

208. On or around March 31, 2014, The Villages submitted a Certificate of Need ("CON") application ("2014 CON Application"), dated March 19, 2014, to DOH.

209. Schedule 1 of the 2014 CON Application states that **Bernard Fuchs** is the sole member and 100% owner of The Villages. A true and correct copy of Schedule 1 of the 2014 CON Application is attached hereto as **Exhibit 51**.

210. Schedule 2 of the 2014 CON application provides information about **Bernard Fuchs'** ownership of other nursing homes, as well as information about his education, experience,

and assets. As to other nursing homes, **Fuchs** disclosed ownership interests in three facilities in New York State and none outside the State. A true and correct copy of Schedule 2 of the 2014 CON Application is attached hereto as **Exhibit 52**.

211. Schedule 14B of the 2014 CON Application includes Section III, which asks "Will the applicant be managed by managers who are not members?" and provides "If yes, attach the proposed Management Agreement between the applicant and the manager" which must meet enumerated requirements and is subject to DOH approval. The Villages checked "No" in response to this Section III. A true and correct copy of Schedule 14B of the 2014 CON Application is attached hereto as **Exhibit 53**.

212. On or around January 28, 2016, The Villages submitted a second CON application ("2016 CON Application"), signed by Fuchs, seeking approval to modify Fuchs' share in The Villages (from 100% to 3.32%) and expand ownership of The Villages to include Respondents **Edelstein** (3.32%), **Freund** (3.32%), **G. Fuchs** (3.32%), **T. Fuchs** (3.32%), **Gast** (20.99%), **Halper** (12.33%), **Lahasky** (16.66%), **Farkovits** (16.66%), **Lichtschein** (7.5%), and **Korngut** (9.16%). This proposed ownership composition substantially mirrors Telegraph's ownership composition. A true and correct copy of Schedule 1 of the 2016 CON Application is attached hereto as **Exhibit 54**.

213. As set forth in a November 16, 2017 Letter from Brian W. Morris to Deborah Lynch, DOH made various inquiries in response to the 2016 CON Application, including asking very specific information about the proposed new owners, their ownership interests in certain facilities, explanations for poor performance at various facilities in and out of state, and turnaround plans for said facilities. DOH further requested that Respondents **Gast**, **Lahasky**, and **Farkovitz** certify that they had no "current or past operational ownership" in The Villages. A true and correct

copy of the Letter from Brian W. Morris to Deborah Lynch, dated November 16, 2017 is attached hereto as **Exhibit 55**.

214. As set forth in the February 28, 2018 Letter from Barbara DelCogliano to Deborah Lynch, The Villages did not respond to these multiple inquiries. As a consequence, on or around February 28, 2018, DOH deemed the application abandoned, and Fuchs therefore remains the sole owner of The Villages. A true and correct copy of the February 28, 2018 Letter from Barbara DelCogliano to Deborah Lynch is attached hereto as **Exhibit 56**.

215. As set forth in the August 14, 2014 Letter from Keith W. Servis to Deborah Lynch, DOH required The Villages to submit "an executed lease agreement that is acceptable to the Department of Health," as a condition for approval of the 2014 CON Application. A true and correct copy of the August 14, 2014 Letter from Keith W. Servis to Deborah Lynch is attached hereto as **Exhibit 57**.

216. As set forth in the Executive Summary to The Villages 2014 CON Application, to satisfy this condition, The Villages submitted a 10-year term lease agreement with Telegraph which provides, *inter alia*, that The Villages will pay rent to Telegraph in the amount of: (a) monthly debt service on the mortgage; and (b) $50,000 per month. A true and correct copy of the Executive Summary to The Villages' 2014 CON Application is attached hereto as **Exhibit 58**.

217. On the other hand, Respondents' Operative Lease Agreement provides, *inter alia*, that The Villages shall pay rent to Telegraph in the amount of: (a) monthly debt service on the mortgage; (b) $50,000 per month; *plus* (c) "profits of up to One Million ($1,000,000) Dollars per annum." (*See* Ex. 50 § 2.1) (emphasis added.)

218. MFCU's investigation found no evidence that The Villages submitted the Operative Lease Agreement to DOH.

219. Moreover, MFCU found that The Villages followed the Operative Lease Agreement in practice, and even exceeded the payments provided for therein. For example, based on information reported on The Villages' 2020 Medicaid Cost Report (Part III (1) – Related Company Financial Data – Payments to Related Companies (continued), debt service on the mortgage for 2020 plus $600,000 ($50,000/ month) amounted to $1,213,998. Nonetheless, The Villages reported $2,655,527 in rental expenses to Telegraph that year – approximately $1.4 million more than what would have been owed according to the First Lease Agreement and $400,000 more than what was owed according to the Operative Lease Agreement.

The Villages Falsely Certified Medicaid Cost Reports.

220. Pursuant to 10 NYCRR § 86-2.2, nursing home providers are required to file complete and accurate annual financial and statistical reports (Medicaid Cost Reports) to DOH. These reports include revenues, expenses, assets, liabilities, and statistical data. The data is used by DOH to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends. True and correct copies of Schedules 4, 5, 7, 9, P, and Exhibit H (and, as to 2020 only, Part III(1)) from The Villages' Medicaid Cost Reports for years 2015-2021 are attached hereto as **Exhibits 59** to **65.**

221. Together with the annual Medicaid Cost Report, nursing home operators are required to submit the following certification to DOH:

> I also certify that all salary and non-salary expenses presented in the RHCF-4 [Cost Report] with the exception of those expenses attributable to Research Physicians' Offices and other Rentals, Gift Shop, Public Restaurant, Fund Raising and Sold Services considering the adjustments contained in the Part II and the recoveries of expenses detailed in Exhibit I of the Part IV ***were incurred to provide patient care in the facility.***

(emphasis added.)

222. The Villages presented rent expenses incurred to Telegraph in its Medicaid Cost Reports.

223. As set forth in paragraph 179 above, according to bank analysis, The Villages paid Telegraph $15,750,360 in rent during the period January 1, 2015, to June 2022, amounting to approximately $2,100,000 per year.

224. As set forth in paragraph 183 above, Telegraph paid $9,826,936 in rent proceeds to the Individual Respondents.

225. This indicates that not "all…non-salary expenses presented in the RHCF . . . were incurred to provide patient care in the facility.

The Villages Did Not Comply with Quality Assessment and Assurance Requirements.

226. The Villages provided MFCU with attendance sheets from 27 QAPI meetings held at The Villages from March 2018 to July 2021. The Medical Director, Dr. Madejski, appears on the attendance sheet for only two of those meetings. Neither Bernard Fuchs nor any other designated "governing body" member appears on any of the attendance sheets provided by The Villages.

227. Comprehensive Healthcare Management Services, LLC, d/b/a Brighton Rehabilitation and Wellness Center is a skilled nursing facility located in Beaver, PA. Its owners include Respondents **Joel Edelstein**, **Israel Freund**, **Gerald Fuchs**, **Tova Fuchs**, **Sam Halper**, **Ephram Lahasky**, **Joshua Farkovits**, and Lahasky LLC.

228. Mt. Lebanon Operations, LLC, d/b/a Mount Lebanon Rehabilitation and Wellness Center is a skilled nursing facility located in Pittsburgh, PA. Its owners include Respondents **Sam Halper**, **David Gast**, and **Ephram Lahasky**.

Exhibits

229. Attached hereto as **Exhibit 1** is a true and correct copy of The Villages' Operating Certificate.

230. Attached hereto as **Exhibit 2** is a true and correct copy of The Villages 2408 Account Signature Card.

231. Attached hereto as **Exhibit 3** is a true and correct copy of the Five Star Bank Limited Liability Company Resolution of Authority for Villages 5897.

232. Attached hereto as **Exhibit 4** is a true and correct copy of The Purchase and Sale Agreement.

233. Attached hereto as **Exhibit 5** is a true and correct copy of the Telegraph Amended Operating Agreement.

234. Attached hereto as **Exhibit 6** is a true and correct copy of the Telegraph Operating Agreement.

235. Attached hereto as **Exhibit 7** is a true and correct copy of the Telegraph 3849 Signature Card.

236. Attached hereto as **Exhibit 8** is a true and correct copy of the CHMS Group Operating Agreement (CHMSGROUP_2000217-247).

237. Attached hereto as **Exhibit 9** is a true and correct copy of the CHMS 8819 Signature Card.

238. Attached hereto as **Exhibit 10** is a true and correct copy of the CHMS 3360 Signature Cards.

239. Attached hereto as **Exhibit 11** is a true and correct copy of the Gast LLC 2691 Signature Card.

240. Attached hereto as **Exhibit 12** is a true and correct copy of Gast LLC 2691 Business Depository Certificate.

241. Attached hereto as **Exhibit 13** is a true and correct copy of the New York State Department of State Entity Information for Gast LLC.

242. Attached here to as **Exhibit 14** is a true and correct copy of the Lahasky 0890 Signature Card.

243. Attached hereto as **Exhibit 15** is a true and correct copy of The Villages' Operating Agreement.

244. Attached hereto as **Exhibit 16** is a true and correct copy of excerpted pages 22-23 from the 2020 Loan Presentation.

245. Attached hereto as **Exhibit 17** is a true and correct copy of excerpted pages 9 and 27-29 from the 2017 Loan Presentation.

246. Attached hereto as **Exhibit 18** is a true and correct copy of the ACM Medical Laboratory Contract (CHMSGroup_000103-114).

247. Attached hereto as **Exhibit 19** is a true and correct copy of the Healthcare Staffing Agreement (CHMSGroup_000178-180).

248. Attached hereto as **Exhibit 20** is a true and correct copy of the PDI Contract (CHMSGroup_000186-191).

249. Attached hereto as **Exhibit 21** is a true and correct copy of the May 6, 2014 IRS Notice.

250. Attached hereto as **Exhibit 22** is a true and correct copy of The Villages' 2015 Medicaid Billing Certification.

251. Attached hereto as **Exhibit 23** is a true and correct copy of Statement of Deficiencies, Exit Date July 31, 2015.

252. Attached hereto as **Exhibit 24** is a true and correct copy of the Statement of Deficiencies, Exit Date October 13, 2015.

253. Attached hereto as **Exhibit 25** is a true and correct copy of the Statement of Deficiencies, Exit Date April 25, 2016.

254. Attached hereto as **Exhibit 26** is a true and correct copy of the Statement of Deficiencies, Exit Date June 22, 2017.

255. Attached hereto as **Exhibit 27** is a true and correct copy of the Statement of Deficiencies, Exit Date July 12, 2017.

256. Attached hereto as **Exhibit 28** is a true and correct copy of the Statement of Deficiencies, Exit Date February 21, 2018.

257. Attached hereto as **Exhibit 29** is a true and correct copy of the Statement of Deficiencies, Exit Date November 16, 2018.

258. Attached hereto as **Exhibit 30** is a true and correct copy of the Statement of Deficiencies, Exit Date April 2, 2019.

259. Attached hereto as **Exhibit 31** is a true and correct copy of the Statement of Deficiencies, Exit Date July 9, 2019.

260. Attached hereto as **Exhibit 32** is a true and correct copy of the Statement of Deficiencies, Exit Date May 9, 2020.

261. Attached hereto as **Exhibit 33** is a true and correct copy of the Stipulation and Order, NH-20-018.

262. Attached hereto as **Exhibit 34** is a true and correct copy of the Statement of Deficiencies, Exit Date August 12, 2020.

263. Attached hereto as **Exhibit 35** is a true and correct copy of the Statement of Deficiencies, Exit Date December 17, 2020.

264. Attached hereto as **Exhibit 36** is a true and correct copy of the DOH Enforcement Letter, dated February 3, 2021.

265. Attached hereto as **Exhibit 37** is a true and correct copy of the Statement of Deficiencies, Exit Date September 24, 2019.

266. Attached hereto as **Exhibit 38** is a true and correct copy of the Statement of Deficiencies, Exit Date February 26, 2020.

267. Attached hereto as **Exhibit 39** is a true and correct copy of the Statement of Deficiencies, Exit Date August 11, 2020.

268. Attached hereto as **Exhibit 40** is a true and correct copy of the Statement of Deficiencies, Exit Date April 26, 2021.

269. Attached hereto as **Exhibit 41** is a true and correct copy of the Statement of Deficiencies, Exit Date October 25, 2021.

270. Attached hereto as **Exhibit 42** is a true and correct copy of the 2019 In-cite Report.

271. Attached hereto as **Exhibit 43** is a true and correct copy of the 2020 Polaris Report (TheVillagesofOrleans_028878-905).

272. Attached hereto as **Exhibit 44** is a true and correct copy of the Affidavit of Kathleen Howard, dated August 13, 2021.

273. Attached hereto as **Exhibit 45** is a true and correct copy of the Facility Assessment Tool (VillagesOfOrleans_103327-337).

274. Attached hereto as **Exhibit 46** is a true and correct copy of the Staffing Policy (VillagesOfOrleans_000832).

275. Attached hereto as **Exhibit 47** is a true and correct copy of the March 2021 Facility Assessment.

276. Attached hereto as **Exhibit 48** is a true and correct copy of the Statement of Deficiencies, Exit Date September 14, 2020.

277. Attached hereto as **Exhibit 49** is a true and correct copy of The Villages' First Lease Agreement.

278. Attached hereto as **Exhibit 50** is a true and correct copy of The Villages' Operative Lease Agreement (VillagesOfOrleans_0000501-520).

279. Attached hereto as **Exhibit 51** is a true and correct copy of Schedule 1 of the 2014 CON Application.

280. Attached hereto as **Exhibit 52** is a true and correct copy of Schedule 2 of the 2014 CON Application.

281. Attached hereto as **Exhibit 53** is a true and correct copy of Schedule 14B of the 2014 CON Application.

282. Attached hereto as **Exhibit 54** is a true and correct copy of Schedule 1 of the 2016 CON Application.

283. Attached hereto as **Exhibit 55** is a true and correct copy of the Letter from Brian W. Morris to Deborah Lynch, dated November 16, 2017.

284. Attached hereto as **Exhibit 56** is a true and correct copy of the Letter from Barbara DelCogliano to Deborah Lynch, dated February 28, 2018.

285. Attached hereto as **Exhibit 57** is a true and correct copy of the Letter from Keith W. Servis to Deborah Lynch, dated August 14, 2014.

286. Attached hereto as **Exhibit 58** is a true and correct copy of the Executive Summary to the 2014 CON Application.

287. Attached hereto as **Exhibit 59** is a true and correct copy of excerpted Schedules 4, 5, 7, 9, P, and Exhibit H from The Villages' 2015 Medicaid Cost Report.

288. Attached hereto as **Exhibit 60** is a true and correct copy of excerpted Schedules 4, 5, 7, 9, P, and Exhibit H from The Villages' 2016 Medicaid Cost Report.

289. Attached hereto as **Exhibit 61** is a true and correct copy of excerpted Schedules 4, 5, 7, 9, P, and Exhibit H from The Villages' 2017 Medicaid Cost Report.

290. Attached hereto as **Exhibit 62** is a true and correct copy of excerpted Schedules 4, 5, 7, 9, P, and Exhibit H from The Villages' 2018 Medicaid Cost Report.

291. Attached hereto as **Exhibit 63** is a true and correct copy of excerpted Schedules 4, 5, 7, 9, P, and Exhibit H from The Villages' 2019 Medicaid Cost Report (VillagesOfOrleans_046646-647, 046656, 046714-715, 046732, 046737-740).

292. Attached hereto as **Exhibit 64** is a true and correct copy of excerpted Schedules 4, 5, 7, 9, P, Part III (1), and Exhibit H from The Villages' 2020 Medicaid Cost Report.

293. Attached hereto as **Exhibit 65** is a true and correct copy of excerpted Schedules 4, 5, 7, 9, P, and Exhibit H from The Villages' 2021 Medicaid Cost Report.

294. Attached hereto as **Exhibit 66** is a true and correct copy of the Statement of Deficiencies, Exit Date April 29, 2020.

295. Attached hereto as **Exhibit 67** is a true and correct copy of The Villages' Medicaid Cost Report Certifications for 2015, 2016, and 2017.

Respectfully submitted,

Milan Shah
Principal Auditor-Investigator

Sworn to before me this
28 day of October, 2022

Notary Public

KELVIN CARABALLO
NOTARY PUBLIC, STATE OF NEW YORK
No. 01CA6295413
Qualified in Westchester County
My Commission Expires 1/6/20 26

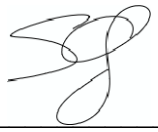
CERTIFICATION PURSUANT TO RULE 202.8-b

I, Soo-young Chang, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit contains 19,233 words, excluding the parts of the Affidavit explicitly exempted by Rule, and that Petitioner's request for permission to file an oversize submission as provided in Rule 202.8-b(f) is forthcoming.

Dated: New York, New York
November 28, 2022

Respectfully submitted,

Letitia James
Attorney General of the State of New York

By: 

SOO-YOUNG CHANG
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Medicaid Fraud Control Unit
Main Place Tower
350 Main Street, Suite 300 B
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(716) 249-5147
Soo-young.Chang@ag.ny.gov

EXHIBIT 1

Facility Id. 716
Certificate No. 3620301N

State of New York
Department of Health
Office of Primary Care and Health Systems Management

Certified Beds - Total **120**
RHCF 120

OPERATING CERTIFICATE
Residential Health Care Facility - SNF

Effective Date: 01/01/2015
Expiration Date: NONE

The Villages of Orleans Health and Rehabilitation Center
14012 Route 31
Albion, New York 14411

Operator: Comprehensive at Orleans LLC
Operator Class: Proprietary LLC

Has been granted this Operating Certificate pursuant to Article 28 of the Public Health Law for the service(s) specified.

Baseline Respite 2

Keith W. Servis

Deputy Director Office of Primary Care and Health Systems Management

Facsimile

Commissioner

20150910

This certificate must be conspicuously displayed on the premises.

EXHIBIT 2

The PrivateBank

BUSINESS ENTITY ACCOUNT SIGNATURE CARD

DATE 12/17/2014	Financial Institution Branch Address 120 South LaSalle St Chicago, IL 60602 Opened By: Eugenia Spina

ACCOUNT INFORMATION

TITLE OF ACCOUNT Comprehensive at Orleans, LLC

ACCOUNT NUMBER [redacted]2408

ACCOUNT T.I.N. [redacted]

600 Broadway
Lynbrook NY 11563-3980

PRODUCT NAME Business Checking

☐ Check box if the Account has a Beneficial Owner that is not the Entity

BUSINESS ENTITY INFORMATION (the "Entity")

Business Name and Address

Comprehensive at Orleans, LLC

600 Broadway
Lynbrook NY 11563-3980

Assumed Name if D/B/A

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is the correct taxpayer identification number for the Entity, (or I am waiting for a number to be issued to me), and
2. The Entity is not subject to backup withholding because: (a) it is exempt from backup withholding, or (b) it has not been notified by the Internal Revenue Service (IRS) that it is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified it that it is no longer subject to backup withholding, and
3. The Entity is a U.S. person.
4. The Entity is exempt from FATCA reporting.

You must cross out Item 2 above if the Entity has been notified by the IRS that it is currently subject to backup withholding because it failed to report all interest and dividends on its tax return.

12-29-14

SIGNATURE Comprehensive at Orleans DATE

☐ See separate W-9 Document

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT. To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.

What this means for you: When you open an account, we will ask you for your name, address, date of birth, and other information that will allow us to identify you and the Entity. We may also ask to see your driver's license or other identifying documents.

ACKNOWLEDGMENT. The Entity agrees to be bound by the rules and conditions of The PrivateBank and Trust Company ("Bank") that govern this account, as they may be amended, including the Business Deposit Account Agreement and Disclosure ("Agreement and Disclosure"). By signing this document, I/We acknowledge on behalf of the Entity that the Agreement and Disclosure has been received. I/We certify that all of the information printed on this signature card and that I/We provided to the Bank is true and accurate, including, without limitation, the names and titles of each of the individuals who have signed below. I/We agree that the Bank has the right to charge this account for any liabilities owed to the Bank by the Entity. All signors are acting on behalf of the Entity.

Any one signature required for Account actions. If this Signature Card relates to a Certificate of Deposit, the individuals that execute below and, if applicable, the attached addendum, shall be authorized to transact business under any account for renewals of such Certificate of Deposit.

☒ Check box if the Entity desires that the individuals that execute below, and if applicable, the attached addendum, be authorized to transact business under all accounts of the Entity with the Bank.

12 / 31 / 2014

X _____ Date
Name: David S. Gest
Title: Member

X 12-29-14 Date
Name: Efram Mordy Lehasky
Title: Member

X _____ Date
Name: Sam Helper
Title: Authorized Signer

X 12/31/14 Date
Name: Benjamin Landa
Title: Member

The PrivateBank

BUSINESS ENTITY ACCOUNT SIGNATURE CARD

DATE 12/17/2014	Financial Institution Branch Address 120 South LaSalle St Chicago, IL 60602 Opened By: Eugenia Spina

ACCOUNT INFORMATION

TITLE OF ACCOUNT Comprehensive at Orleans, LLC

ACCOUNT NUMBER [redacted]2408

ACCOUNT T.I.N. [redacted]

600 Broadway
Lynbrook NY 11563-3980

PRODUCT NAME Business Checking

☐ Check box if the Account has a Beneficial Owner that is not the Entity

BUSINESS ENTITY INFORMATION (the "Entity")

Business Name and Address
Comprehensive at Orleans, LLC

Assumed Name if D/B/A

600 Broadway
Lynbrook NY 11563-3980

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12-29-14

SIGNATURE Comprehensive at Orleans, DATE

☐ See separate W-9 Document

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ACKNOWLEDGMENT. The Entity agrees to be bound by the rules and conditions of The PrivateBank and Trust Company ("Bank") that govern this account, as they may be amended, including the Business Deposit Account Agreement and Disclosure ("Agreement and Disclosure"). By signing this document, I/We acknowledge on behalf of the Entity that the Agreement and Disclosure has been received. I/We certify that all of the information printed on this signature card and that I/We provided to the Bank is true and accurate, including, without limitation, the names and titles of each of the individuals who have signed below. I/We agree that the Bank has the right to charge this account for any liabilities owed to the Bank by the Entity. All signors are acting on behalf of the Entity.

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☒ Check box if the Entity desires that the individuals that execute below, and if applicable, the attached addendum, be authorized to transact business under all accounts of the Entity with the Bank.

X _____ Date
Name: David S Gast
Title: Member

X _____ 12-29-14 Date
Name: Efram Mordy Lahasky
Title: Member

X _____ 12 / 30 / 2014 Date
Name: Sam Halper
Title: Authorized Signer

X _____ Date
Name: Benjamin Landa
Title: Member

The PrivateBank

BUSINESS ENTITY ACCOUNT SIGNATURE CARD

DATE 12/17/2014	Financial Institution Branch Address 120 South LaSalle St Chicago, IL 60602 Opened By: Eugenia Spina

ACCOUNT INFORMATION

TITLE OF ACCOUNT Comprehensive at Orleans, LLC

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ACCOUNT T.I.N. [redacted]

600 Broadway
Lynbrook NY 11563-3980

PRODUCT NAME Business Checking

☐ Check box if the Account has a Beneficial Owner that is not the Entity

BUSINESS ENTITY INFORMATION (the "Entity")

Business Name and Address

Comprehensive at Orleans, LLC

600 Broadway
Lynbrook NY 11563-3980

Assumed Name if D/B/A

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is the correct taxpayer identification number for the Entity, (or I am waiting for a number to be issued to me), and
2. The Entity is not subject to backup withholding because: (a) it is exempt from backup withholding, or (b) it has not been notified by the Internal Revenue Service (IRS) that it is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified it that it is no longer subject to backup withholding, and
3. The Entity is a U.S. person.
4. The Entity is exempt from FATCA reporting.

You must cross out Item 2 above if the Entity has been notified by the IRS that it is currently subject to backup withholding because it failed to report all interest and dividends on its tax return.

SIGNATURE Comprehensive at Orleans, 12/22/14 DATE ☐ See separate W-9 Document

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT. To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.

What this means for you: When you open an account, we will ask you for your name, address, date of birth, and other information that will allow us to identify you and the Entity. We may also ask to see your driver's license or other identifying documents.

ACKNOWLEDGMENT. The Entity agrees to be bound by the rules and conditions of The PrivateBank and Trust Company ("Bank") that govern this account, as they may be amended, including the Business Deposit Account Agreement and Disclosure ("Agreement and Disclosure"). By signing this document, I/We acknowledge on behalf of the Entity that the Agreement and Disclosure has been received. I/We certify that all of the information printed on this signature card and that I/We provided to the Bank is true and accurate, including, without limitation, the names and titles of each of the individuals who have signed below. I/We agree that the Bank has the right to charge this account for any liabilities owed to the Bank by the Entity. All signors are acting on behalf of the Entity.

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☒ Check box if the Entity desires that the individuals that execute below, and if applicable, the attached addendum, be authorized to transact business under all accounts of the Entity with the Bank.

X Name: Joel Edelstein Title: Member 12-22-14 Date	X Name: Title: Date
X Name: Title: 12 / 30 / 2014 Date	X Name: Title: Date

EXHIBIT 3

LIMITED LIABILITY COMPANY RESOLUTION OF AUTHORITY

****

Five Star Bank
(Financial Institution)

NOVEMBER 24, 2014
(Date Accepted by the Financial Institution)

By: COMPREHENSIVE AT ORLEANS LLC
(Trade Name of Company)

14012 ROUTE 31
(Address)

ALBION NY 14411-9353
(City, State and Zip Code)

Date: NOVEMBER 24, 2014

Federal I.D. Number: [redacted]

The above limited liability company ("Company") consists of the following Members:

BE RESOLVED THAT, the above-named parties constitute all the Members of this Company, and by signing below, agree that:

1. The Financial Institution named above is designated as a depository for the funds of this Company.
2. This resolution shall continue to have effect until express written notice of its rescission or modification has been received and recorded by this Financial Institution. Any and all prior resolutions adopted by this Company and certified to this Financial Institution as governing the operation of this Company's account(s), are in full force and effect, unless supplemented or modified by this authorization.
3. All transactions, if any, with respect to any opening of account(s), deposits, withdrawals, rediscounts and borrowings by or on behalf of this Company with this Financial Institution prior to the adoption of this resolution are hereby ratified, approved and confirmed.
4. Any of the persons named below, so long as they act in a representative capacity as agents of this Company, are authorized to make any and all other contracts, agreements, stipulations and orders which they may deem advisable for the effective exercise of their powers indicated below, from time to time, with this Financial Institution, concerning funds deposited in this Financial Institution, moneys borrowed from this Financial Institution or any other business transacted by and between this Company and this Financial Institution subject to any restrictions stated below.
5. Any and all prior resolutions adopted by the Members of this Company and certified to this Financial Institution as governing the operation of this Company's account(s), are in full force and effect, unless explicitly supplemented or modified by this authorization or previously revoked or cancelled in a written instrument delivered to and recorded by this Financial Institution.
6. If any other parties become interested in this Company as Co-Members, the Company relationship is altered in any way, or if the business should become incorporated, the Members shall notify this Financial Institution promptly.
7. This Company agrees to the terms and conditions of any account agreement, properly opened by any authorized representative(s) of this Company, and authorizes the Financial Institution named above, at any time, to charge this Company for all checks, drafts, or other orders, for the payment of money, that are drawn on this Financial Institution, regardless of by whom or by what means the signature(s) thereto may have been affixed, so long as they resemble the signature specimens shown below (or the signature specimens that this Company files with this Financial Institution from time to time) and contain the required number of signatures for this purpose.
8. Transfer of funds:
   a. This Financial Institution is authorized to honor any written instructions (including, but not limited to, requests for loan advances and wire transfer requests) that may be received by the Financial Institution from time to time via

electronic mail, telephone, facsimile machine or other device customarily used in business, directing the transfer of funds to or from the Company's accounts at the Financial Institution provided that said instructions bear, or appear to bear, the signatures of the required number of Authorized Members/Managers, and such signatures on the facsimile, regardless of how or by whom affixed, resemble the specimen signatures filed with the Financial Institution, and the Financial Institution shall have no duty to inquire further.

b. The Company acknowledges and agrees that

(i) in furthering the transfer, the Financial Institution may make use of any banking channels or other facilities which it may elect, all without liability for any acts or failures to act (including any failure to identify the intended transferee), on the part of any of its branches or correspondents, or for any failure of the amount to reach the intended transferees;

(ii) if the Financial Institution has been instructed to make a wire transfer but is unable to do so with reasonable promptness, the Financial Institution may proceed to effect the transfer by any means that it shall deem expedient in the circumstances;

(iii) the Financial Institution may send any message about a transfer in any language or medium and shall not be liable for errors, delays or defaults in the transmission of any message by mail or wire facilities employed by it or by any of its branches or correspondents or for any total or partial suspension of the means of transmission; and

(iv) if a refund is requested prior to the completion of the transfer, the Financial Institution will attempt to effect a cancellation of any instruction to pay which it may have issued and, upon receipt by it of confirmation of cancellation and the return to it of whatever funds it may have previously paid or credited to any third party for the purpose of furthering the transfer, the Financial Institution will refund the amount, less its expenses and those of any correspondent or other party for the transfer, to the Company.

9. The Authorized Members/Managers are individually empowered to delegate to other persons the authority to perform transactions with respect to the accounts of this Company, such authority being more particularly described in documents delivered to the Financial Institution in such form as the Financial Institution may require, and to change and revoke such delegations from time to time; that the Financial Institution is entitled to rely upon such delegations of authority and to accept instructions from such other persons as being fully authorized by this Company.

10. The Company shall indemnify, defend and hold harmless the Financial Institution from and against any and all claims, losses, liabilities, costs, damages and expenses (including costs of settlement and appeal and reasonable attorney fees) which the Financial Institution may sustain or incur by reason of its having acted at any time in reliance upon any certification by any member or manager of the Company to the Financial Institution of this, or any other resolution, or of the signature of any member/manager of the Company (or his or her delegate).

11. The Company hereof approves the loan documents, including, but not limited to, the Promissory Note, Mortgage, Security Agreement, Assignment of Leases, Rents and Profits and any other loan documents evidencing the loan or loans from Bank to Company.

12. That the Company acknowledges and agrees that in the event that Company, either prior or subsequent to the date of this resolution:

a. submits or has submitted other resolutions of the Company to the Financial Institution, and/or

b. enters or has entered into any account agreements or other agreements with the Financial Institution which conflict with the terms of this resolution,

then the Financial Institution may act in accordance with any of the resolutions and/or agreements, without liability whatsoever to the Company, until such time as the Company has expressly revoked or canceled the conflicting provisions of any such resolution or agreement in a written instrument delivered to, and recorded by, the office of the Financial Institution at the following address:

(i) Five Star Bank, P.O. Box 110, Warsaw, New York 14569, Attention: Banking Center

13. If applicable, this Company has filed a written document in the State of New York in accordance with local law and has received permission to use an assumed name/dba Certificate which is: __

If indicated, any person listed below (subject to any expressed restrictions) is authorized to

	Name and Title	Signature
(A)	BERNARD FUCHS PRESIDENT	
(B)	EPHRAM MORDY LAHASKY SECRETARY	
(C)	JOEL EDELSTEIN MEMBER	
(D)		

Indicate A, B, C and/or D

A,B,C (1) Exercise all of the powers listed in (2) through (7).

A,B,C (2) Open any deposit or checking account(s) in the name of this Company.

A,B,C (3) Endorse checks and orders for the payment of money and withdraw funds on deposit with this Financial Institution.

Number of authorized signatures required for this purpose: 1.

A,B,C (4) Borrow money on behalf and in the name of this Company, sign, execute and deliver promissory notes or other evidences of indebtedness and execute and deliver loan documents to pledge collateral for such indebtedness.

Number of authorized signatures required for this purpose: 1.

A,B,C (5) Endorse, assign, transfer, mortgage or pledge bills receivable, warehouse receipts, bills of lading, stocks, bonds, real estate or other property now owned or hereafter owned or acquired by this Company as security for sums borrowed, and to discount the same, unconditionally guarantee payment of all bills received, negotiated or discounted and to waive demand, presentment, protest, notice of protest and notice of non-payment.

Number of authorized signatures required for this purpose: 1.

A,B,C (6) Enter into written lease for the purpose of renting and maintaining a Safe Deposit Box in this Financial Institution.

Number of authorized signatures required to gain access and to terminate the lease: 1.

A,B,C (7) Enter into any arrangement with this Financial Institution, such as remote deposit capture, cash management, bill payment, automated clearing house. or other services or products offered by this Financial Institution.

Number of authorized signatures required to enter into any written agreement in connection with this purpose: 1.

IN WITNESS WHEREOF, I have hereunto subscribed my name and, if possible, affixed the seal of this Company on NOVEMBER 24, 2014

Limited Liability Company Name: NOVEMBER 24, 2014

Signature: Bernard Fuchs

Print Name and Title: BERNARD FUCHS PRESIDENT

Witness: Jamie Bennett
Five Star Bank
JAMIE BENNETT
CSR

Signature: Jamie Bennett

Print Name and Title:

Witness: _____
Five Star Bank

Signature: _____

Print Name and Title: _____

Signature: _____

Print Name and Title: _____

EXHIBIT 4

THIS PURCHASE AND SALE AGREEMENT, made this 6th day of February, 2014 (herein, the "Agreement"), by and between the **ORLEANS COUNTY HEALTH FACILITIES CORPORATION**, not-for-profit local development corporation duly organized and validly existing under the laws of the State, having an office for the transaction of business at 3 South Main Street, Albion, New York 14411 (herein, the "Corporation" or "Seller"), **COMPREHENSIVE AT ORLEANS LLC**, a New York limited liability company (the "Operator") and **TELEGRAPH REALTY LLC**, a New York limited liability company (the "Real Property Purchaser" and collectively with the Operator, the "Purchaser," and the Corporation, Operator and the Real Property Purchaser are sometimes referred to herein as "Parties").

WITNESSETH:

WHEREAS, the COUNTY OF ORLEANS, NEW YORK (herein, the "County"), operates the Orleans County Nursing Home Facility known as The Villages of Orleans Health and Rehabilitation Center located at 14012 Route 31 West, Albion, New York, operated by the County under Certificate No. 3620300N as a 120-bed Residential Health Care Facility (the "Facility"); and

WHEREAS, the County has determined that efficiency in government services is an important goal throughout the State of New York given the fiduciary responsibility to the taxpayers and given the state of fiscal affairs presently existing within the State and within the County; and

WHEREAS, pursuant to Resolution Number 86-213 of 2013, adopted February 27, 2013 (herein, the "**County Authorizing Resolution**"), the County authorized (i) the undertaking of a certain Disposition, as defined within the County Authorizing Resolution and more particularly described herein (collectively, the "Disposition and Transfer") of a fee and/or leasehold interest to the Corporation of portions of a certain parcel of land associated with the Facility, along with the buildings and improvements located thereon, along with the Facility Business Assets, as defined herein; and (ii) reservation by the County of rights to continue operating the Facility Assets until the Disposition and Transfer is undertaken by the Corporation; and

WHEREAS, pursuant to Section 1411 of the Not-for-Profit Corporation Law of the State, the Corporation was established as a not-for-profit local development corporation of the State pursuant to the filing of a Certificate of Incorporation with the New York Secretary of State on the 8th day of March, 2013; and

WHEREAS, in furtherance of the foregoing, and in accordance with the County Authorizing Resolution, the County and the Corporation previously entered into a certain Lease Agreement with Exclusive Option to Purchase, dated as of March 8, 2013 (the "Lease Agreement"), wherein the Corporation leases the Facility from the County and is granted an exclusive option to acquire the Facility Assets (the "Option", as more particularly defined within the Lease Agreement), and, so as to reflect the reservation of rights by the County to continue to operate the Facility until its rights are terminated by the Corporation, a reservation of rights agreement styled as a Leaseback Agreement, was entered into and also dated as of March 8, 2013 (the "Leaseback Agreement"); and

WHEREAS, the Corporation issued a certain Offering Memorandum (the "**Offering Memorandum**") and Request for Proposals ("**RFP**") relating to the Disposition and Transfer; and

WHEREAS, the Corporation received responses to the Offering Memorandum and RFP from proposers to purchase the Facility Assets, pursuant to the terms of the Offering Memorandum; and

WHEREAS, the Corporation has selected the proposal submitted by Bernard Fuchs, Mordy Lahasky and Benjamin Landa (collectively herein, the "Guarantors") on behalf of an entity to be formed; and

WHEREAS, the Guarantors have caused the formation of the Operator and the Real Estate Purchaser for purposes of carrying out the Transfer of the Facility Assets and serving as Selected Operator; and

WHEREAS, the Corporation, the Operator and the Real Estate Purchaser desire to enter into this Agreement to establish the terms and conditions under which the Operator and the Real Estate Purchaser will acquire the Facility Business Assets and Facility Real Property, respectively (as such terms are further defined herein) and the terms and conditions under which the Corporation will undertake the Transfer of the Facility Assets; and

WHEREAS, on or after the date of this Agreement, the Purchaser shall identify an affiliate of the Operator as a service provider (the "**Service Provider**"), and the Seller and County shall enter into an agreement to address access for the Service Provider

WHEREAS, contemporaneously with the execution and delivery of this Agreement, the County and Purchaser or its affiliate shall enter into an Facility Transition Agreement setting forth (i) certain covenants and representations of the County relative to the Facility and the County's continued operation thereof in accordance with the Leaseback Agreement; (ii) certain representations and agreements of the County relating to the transfer of certain operational assets from the County to Purchaser; (iii) covenants by and among the County and Purchaser with respect to the transition of operations of the Facility as of the Closing Date and; (iv) to address certain transitional issues (the "**Transition Agreement**"), such Transition Agreement setting forth certain rights and obligations, representations and covenants of The County and the Purchaser.

NOW, THEREFORE, in consideration of the mutual premises and obligations set forth herein, the Parties hereto, intending to be legally bound hereby, agree as follows:

ARTICLE I

GENERAL

Section 1.1 Definitions. Words and terms that are used herein as defined terms shall (unless otherwise defined herein or unless the context clearly requires otherwise) have the following meanings:

"Acquisition Price" means the price to be paid by the Purchaser to the Corporation under this Agreement for the purchase of the Facility Assets.

"Act of Bankruptcy" means that either of the Operator or the Real Property Purchaser (a) shall have commenced a voluntary case under any bankruptcy law, applied for or consented to the appointment of, or the taking of possession by, a receiver, trustee, assignee, custodian or, liquidator of all or a substantial part of its assets; (b) shall have admitted in writing the inability generally, to pay its debts as such debts become due; (c) shall have made a general assignment for the benefit of creditors; (d) shall have been adjudicated a bankrupt, or shall have filed a petition or an answer seeking an arrangement with creditors; (e) shall have taken advantage of any insolvency law, or shall have submitted an answer admitting the material allegations of a petition in bankruptcy or insolvency proceeding; or (f) an order, judgment or decree for relief in respect of the Operator or the Real Property Purchaser shall have been entered in an involuntary case, without the application, approval or consent of the Operator or the Real Property Purchaser by any court of competent jurisdiction appointing a receiver, trustee, assignee, custodian or liquidator for the Operator or the Real Property Purchaser or for a substantial part of any of its assets and such order, judgment or decree shall continue unstayed and in effect for any period of one hundred eighty (180) consecutive days; (g) the Purchaser shall have filed a voluntary petition in bankruptcy; (h) the Operator or the Real Property Purchaser shall have failed to remove an involuntary petition in bankruptcy filed against it within one hundred eighty (180) days of the filing thereof; or (i) an order for relief shall have been entered against the Operator or the Real Property Purchaser under the provisions of the United States Bankruptcy Act, 11 U.S.C.A.§ 301.

"ALTA Policy" means a Standard American Land Title Association Owner's Form Policy of Title Insurance in the amount of the Acquisition Price with respect to the Facility Real Property, issued by a title insurance company authorized to insure titles to real property in the State subject only to the Permitted Encumbrances.

"Applicable Laws" means the Facility Licenses and all other licenses applicable to the Facility and any statute, law, constitution, charter, ordinance, resolution, judgment, order, decree, rule, regulation, directive, interpretation, ordinance, standard or similarly binding authority, which shall be enacted, adopted, promulgated, issued or enforced by a Governmental Body relating to the Operator or the Real Property Purchaser, the Facility, the Facility Assets, the Facility Real Property, the County (to the extent related to the Facility and/or the Facility Assets), including, but not limited to, permits, licenses, certificates of occupancy.

"Contract Date" means the date of execution of this Agreement by the Parties.

"CON Approval" means the issuance of a final non-contingent Certificate of Need ("CON") by the PHHPC to the Operator to operate the Facility as a skilled nursing facility without any conditions Operator deems unacceptable.

"DOH" means the New York State Department of Health, or any successor agency to which the powers of the DOH have been transferred.

"Environmental Laws" means all federal, state, county and local laws, rules, ordinances, regulations, governmental, administrative or judicial orders or decrees or other legal requirements of any kind governing pollution or contamination of the environment, occupational health and safety.

"Environmental Permits" means all permits, authorizations, approvals, registrations, certificates, licenses or consents required by Environmental Laws in connection with the Corporation's transfer of ownership of the Assets and the County's operation of the Facility.

"Escrow Agent" shall mean Harris Beach PLLC.

"Event of Default" means any event which is specified as such under the terms of Article VI hereof.

"Excluded Assets" means the assets described in Section 2.3 hereof.

"Governmental Body" means, as appropriate, anyone or several of: the United States of America, the State, the County, or any court of competent jurisdiction, agency, authority, regulatory body or political subdivision of the United States of America, the State or the County that may have jurisdiction over or power and authority to regulate the Operator or the Real Property Purchaser, the Facility, the Facility Assets and/or the County (to the extent related to the Facility and/or the Facility Assets).

"Hazardous Materials" means asbestos, urea formaldehyde, polychlorinated biphenyls, nuclear fuel or materials, chemical waste, radioactive materials, explosives, known carcinogens, petroleum products or other dangerous, toxic, or hazardous pollutant, contaminant, chemical, material or substance defined as hazardous or as a pollutant or contaminant in, or the release or disposal of which is regulated by, any State or federal law or regulation. "Disposal" shall be defined in the same manner as that term is defined in the Rules and Regulations of the Department of Environmental Conservation at 6 NYCRR Part 370.2(b)(48). "Release" shall be defined in the same manner as that term is defined at 42 U.S. Code, Section 9601(22).

"Facility Assets" means, collectively, the Facility Business Assets, and the Facility Real Property and all other assets set forth in Section 2.2.

"Facility Business Assets" has the meaning set forth within **Section 2.2(b)** hereof.

"Facility License" means the Certificate of Need issued by the DOH and/or PHHPC to the County, pursuant to which the County operates the Facility as a 120-bed skilled nursing facility, together with all other rights and obligations the County may have with respect to the Facility.

"Facility Licensed Capacity" means the number of licensed beds (120) at the Facility, as evidenced by the Facility License.

"Facility Real Property" has the meaning set forth within Section 2.2(a) hereof.

"Guarantors" shall mean Bernard Fuchs, Mordy Lahasky and Benjamin Landa.

"Material Issue" means either any single issue, circumstance or fact or series of issues, circumstances or facts, with respect to the Facility Assets discovered and documented in a third-party report or otherwise that creates a potential liability or expense to Purchaser for repair or remedial costs or other expense, liability or obligation equal to or greater than Two Hundred Fifty Thousand Dollars ($250,000).

"Permitted Encumbrances" means any of the following:

(a) minor defects and irregularities in the title to the Facility Real Property that do not materially impair use of the Facility Real Property in the manner contemplated by the terms of this Agreement as a skilled nursing facility with 120 licensed beds or render title to the Facility Real Property unmarketable and do not materially impair the use of such property for the purposes for which it is or may reasonably be expected to be held by the Real Property Purchaser;

(b) easements, exceptions, restrictions or reservations, and rights-of-way for the purpose of pipelines, telephone lines, telegraph lines, power lines and substations, roads, streets, highways, railroad purposes, drainage and sewerage purposes, or canals, laterals, ditches, and other like purposes, or for the joint and common use of the Facility Real Property that do not materially impair the use of such property for the purposes for which it is or may reasonably be expected to be held; provided, however that the ALTA Policy issued at Closing affirmatively insures (to the extent such affirmative insurance is available) against the Real Property Purchaser's loss or damage arising out of or relating to such items or by reason of any encroachment, overlap, boundary, dispute or private easement and further insures (to the extent such insurance is available) that none of such items interfere with the use of the Facility Real Property as a long term care facility with 120 beds

(c) rights, identified in the ALTA Policy and subject to the Real Property Purchaser's reasonable approval, that are reserved to or vested in any municipality or governmental or other authority to control or regulate or use in any manner any portion of the Facility Real Property which do not materially impair the use of such property for the purposes for which it is or may reasonably be expected to be held by the Real Property Purchaser;

(d) present zoning laws and ordinances pertaining to the Facility Real Property and its present use, which are not violated; and

(e) easements for ingress and egress for vehicular and pedestrian traffic and easements for installation and maintenance of utilities as reasonably determined and agreed upon from time to time by the Seller or Orleans County and the Real Property Purchaser.

"PHHPC" means the New York State Public Health and Health Planning Council, or any successor agency to which the powers of the PHHPC have been transferred.

"**Regulated Assets**" means (i) certain resident funds, resident interest bearing accounts, patient data and records, resident records and other assets that by federal and State Law or regulation are held by the County as licensed operator for the benefit of the respective patients at the Facility, as such may be more particularly described within the Transition Agreement; (ii) the County's Medicare and Medicaid provider numbers relating to the Facility; (iii) to the extent transferable, the Facility License and any applicable third party payor agreements; and (iv) those portions of the Facility Business Assets that are regulated by Applicable Law and must be transferred by the County directly to the Operator, as more particularly defined within the Transition Agreement.

"**State**" means the State of New York.

Section 1.2 Interpretation. The terms "herein," "hereunder," "hereby," "hereto," "hereof," and similar terms, refer to this Agreement; the term "heretofore" means before the Contract Date; and the term "hereafter" means after the Contract Date. Unless otherwise noted, the words "include," "includes," and "including," as used in this Agreement, shall be deemed to be followed by the phrase "without limitation." The words "agree," "agreements," "approval," and "consent," as used in this Agreement shall be deemed to be followed by the phrase "which shall not be unreasonably withheld or unduly delayed," except as may otherwise be specified. Words importing the masculine gender include the feminine gender or the neuter and vice versa, as the case may be. Words importing the singular number include the plural number and vice versa.

Section 1.3 Time of the Essence. All dates and times set forth in this Agreement are "OF THE ESSENCE", the specified time and dates in this Agreement shall be performed on or before such time as set forth in this Agreement, subject to applicable notice and cure periods.

Section 1.4 Costs. Other than as expressly set forth herein, the following third party costs relating to the sale and settlement of the Facility Assets shall be the sole obligation of the Purchaser: all costs relating to the sale and settlement of the Facility Assets, including but not limited to, recording the deed, any and all transfer tax associated with the transfer, all searches, survey, all title company settlement charges and title insurance costs, closing expenses, legal expenses of the Corporation, settlement fees, environmental investigations, title search fees, insurance fees, appraisal fees, survey fees, and any and all other costs associated with the conveyance. Seller shall be responsible for all amounts due to the Broker and all other closing costs not expressly assumed by Buyer hereunder. Costs incurred prior to execution of the Agreement include survey ($12,000), Phase I ($1,300), and Abstract ($1,000) with the total not exceeding $15,000.

Section 1.5 Due Diligence. After execution of this Agreement, Purchaser shall have the opportunity to employ one or more environmental consultants and other professionals to perform or complete an environmental inspection and assessment of the Facility, and/or to employ engineers or others to perform a physical examination of the buildings, fixtures and systems at the Facility to determine their condition. Purchaser and Purchaser's agents also have

the right to undertake or complete a technical review of all documentation, reports, plans, studies and other information made available by the Corporation regarding the environmental condition of the Premises and/or its physical condition, which the Corporation has made available to Purchaser and Purchaser's agents for review and copying.

ARTICLE II
CONVEYANCE OF THE FACILITY ASSETS

Section 2.1 General Overview/Description of Closing.

In order to effectuate the transactions contemplated by this Agreement, in accordance with the County Authorizing Resolution and Lease Agreement, and subject to the terms of this Agreement, the Corporation shall transfer all right, title and interest in the Facility Real Property and the Facility Business Assets to the Real Property Purchaser and the Operator, respectively, on or after December 31, 2014 but before June 30, 2015 (the "**Closing Date**"). Subject only to the conditions and contingencies set forth herein, the Closing shall take place at the offices of the County, 3 South Main Street, Albion, New York, or at such other location as the Parties may mutually designate in writing. Notwithstanding the foregoing, Seller and the Purchaser may deliver all their respective closing documents required hereunder to the Escrow Agent on or before the Closing Date (to hold in escrow in accordance with customary conveyance practices subject to the consummation of the closing) by mail or overnight delivery. Purchaser shall accept title to the Facility Assets in their then present condition, WHERE-IS and AS-IS as defined in Section 7.10.

The Corporation and Purchaser shall use their best efforts to close the transaction at midnight separating December 31, 2014 from January 1, 2015. ("**Target Transition Date**"). In the event that the Closing does not occur due to failure of DOH to grant unconditional CON approval on or prior to the Target Transition Date, provided Purchaser is taking commercially reasonable efforts to expedite the CON approval, Purchaser shall be permitted to extend such closing date month- by-month under the following terms and condition:

(a) The individual members of the Purchaser shall provide net worth statements in excess of the Acquisition Price, provided the Corporation shall provide reasonable assurances that all financial information shall be confidential and remain confidential and not be subject to public disclosure ("**Ability to Pay**");

(b) The Purchaser shall pay monthly, commencing on January 1, 2015, and every first of the month thereafter through Closing or December 31, 2015 should the Closing not occur through no fault of the Corporation, 10% of the Facility's Budgeted Operational Loss excluding depreciation (defined below) for the calendar year 2015 (the "**2015 Purchase Price Adjustment**") but in no event shall such payment exceed Three Hundred Thousand and no/100 Dollars ($300,000) per month;

(c) The 2015 Budgeted Operational Loss shall be determined by the Orleans County Chief Administrative Officer in accord with GASB and as approved by the Orleans County

Legislature as represented by any appropriation of County funds for operations after December 31, 2014 (see Exhibit 2.1(c));

(d) At, or as soon after the Closing as practicable, there shall be a reconciliation of the Actual Operational Losses (excluding depreciation) of the Facility (see below) as against the Budgeted Operational Losses. To the extent there has been an overpayment by Purchaser, Purchaser shall either receive a credit at Closing or payment by the Corporation. To the extent there has been an underpayment by Purchaser (calculated at an amount not to exceed $300,000 per month) the Corporation shall either receive a credit at Closing or payment from Purchaser. The Actual Operational Loss shall be calculated in accord with GASB as reflected on Exhibit 2.1 (d) attached. Any reconciliation with respect to IGT shall be made when IGT actually received and shall relate only to IGT attributable to the 2015 operational year revenue related to Resident Days provided by the Facility in calendar year 2015 and shall not include any IGT payments received with respect to any other operational year other than the 2015 operational year;

(e) If, by October 15, 2015, the Purchaser is unable to provide: (i) that it has the continued Ability to Pay; and (ii) that the CON approval will be forthcoming for a closing by no later than December 31, 2015, then the Corporation and the Purchaser shall each have the right to terminate this Agreement on written notice ("**Termination Notice**") to the other party delivered on or before November 1, 2015. If the Purchaser has provided the Termination Notice, the termination date shall be as of November 1, 2015 and the Corporation shall retain and recover the Deposit and the 2015 Purchase Price Adjustment, including any payments due but not yet paid, as liquidated damages without further rights or obligations of Purchaser or obligations of the Corporation hereunder. If the Corporation has provided the Termination Notice, the termination date shall be deferred until December 31, 2015; provided, i) the Corporation shall have the right in said event to immediately contract with another party for the sale of the Facility Assets on or after December 31, 2015 subject to the Purchaser's failure to close on December 31, 2015, and ii) the Purchaser shall have the right to continue to pursue the Closing and the Corporation will be bound by this Agreement provided the Closing occurs on or before December 31, 2015. In the event, the Closing has not occurred by December 31, 2015, the Corporation shall retain and be entitled to the Deposit and 2015 Purchase Price Adjustment as liquidated damages without further rights or obligations of Purchaser or obligations of the Corporation hereunder. In the event neither party exercises the rights to terminate this Agreement described in this Section 2.1 by November 1, 2015, and thereafter the Purchaser fails for any reason or no reason to close on the purchase of the Facility Assets by December 31, 2015, the Corporation shall retain the Deposit and the 2015 Purchase Price Adjustment as liquidated damages and the parties shall thereafter have no further rights or obligations under this Agreement. In no event shall the 2015 Purchase Price Adjustment be credited to the Acquisition Price;

(f) In the event, the Purchaser shall default in any payment or obligation hereunder after applicable notice and cure period, the Corporation shall retain and be entitled to the Deposit and 2015 Purchase Price Adjustment as liquidated damages without further rights or obligations of Purchaser or obligations of the Corporation hereunder.

Section 2.2 Description of Facility Real Property and the Facility Business Assets.

(a) Facility Real Property. The "**Facility Real Property**" to be conveyed by the Corporation to the Real Property Purchaser is (x) a 9.305 acre parcel of real property located at 14012 Route 31 West, Albion, New York (bearing TMID No. 72.-2-22 - a portion), all as more particularly described in **Exhibit A** attached hereto and made a part hereof, together with all rights to use and enjoy the Easements, and (y) subject to the Permitted Encumbrances, all right, title, and interest of Corporation, if any, in and to (i) the land constituting any public street, road or avenue, opened or proposed, in front of, adjoining or dissecting such parcel, (ii) all privileges appurtenant or related to such parcel, (iii) all easements, rights-of-way of use, privileges, licenses, appurtenances and rights belonging or appertaining to such parcel, including without limitation all that are necessary or appropriate for the continued operation and maintenance of the Facility for its intended purposes herein; with the understanding that the Corporation and the County have adjoining property interests; and (iv) all buildings, structures, fixtures, facilities, installations and other improvements of every kind and description now or hereafter in, on, over and under such parcel, including, without limitation, any and all plumbing, air conditioning, heating, ventilating, mechanical, electrical and other utility systems, and fixtures, parking lots and facilities, landscaping, roadways, fences, mail boxes, sidewalks, maintenance buildings, security devices, signs and light fixtures.

(b) Facility Business Assets. The Facility Business Assets to be conveyed to the Operator are all right and title to and interest in all of the personal property assets of every kind, nature and description, tangible and intangible, used for or in connection with the operation of the Facility, whether owned, leased, or otherwise but only to the extent they are the subject of the Lease Agreement and related Option, excluding only the specific assets included in the Excluded Assets as defined in **Section 2.3** hereof (collectively, the "**Facility Business Assets**"), free and clear of any and all liens of any kind, but including without limitation, the following:

(i) Furniture and Equipment. All beds, furniture, medical and nursing equipment, materials, appliances, tools, vehicles, spare parts, supplies, and other tangible personal property of every kind, character, and description utilized and/or owned by the County or the Corporation and located on, and used at or primarily in connection with, the Facility and/or the Facility Real Property as of the date hereof or acquired prior to the Closing, including without limitation the assets and properties listed on **Exhibit A-1**.

(ii) Inventories. All inventory (including food, supplies and drugs) on hand at the Facility on the Closing Date, to the extent owned by the Corporation else said assets will be transferred by the County under the Transition Agreement. All Inventory transferred on the Closing Date will be such quantity of food, supplies and drugs as is consistent with past practice, in the ordinary course of business of the Facility.

(iii) Computers. All of the County's or Corporation's computer equipment and hardware, including without limitation all central processing units, terminals, disk drives, tape drives, electronic memory units, printers, keyboards, screens, peripherals (and other input/output devices), modems and other communication controllers, and any and all parts and appurtenances thereto, and to the extent assignment is permitted

by any third parties, all third party hardware, software and shareware to the extent accepted by Purchaser, located on, and used at or primarily in connection with the Facility and/or the Facility Real Property, as of the Closing Date, and specifically including without limitation the computer equipment and hardware listed on **Exhibit A-1**. Notwithstanding the foregoing, all data shall be transferred on the Closing Date in a form to be agreed to by the Parties.

(iv) Intellectual Property. All intellectual property (other than licensed commercially available third party software requiring consent to assignment or transfer, then only to extent consent is obtained at Purchaser expense) relating to, or used in connection with the operation of the Facility and/or the Facility Real Property, including without limitation the intellectual property listed on **Exhibit A-1**, and all rights to recover for infringement thereon.

(v) Trade Names and Telephone Numbers. All right, title, and interest of the County or the Corporation in and to the names listed on **Exhibit A-1** including any website domain names, telephone numbers, and any derivative thereof, together with any goodwill associated with such name.

(vi) Permits. To the extent assignable, all right, title, and interest of the County in, to, and under all permits, licenses, certificates, waivers, consents, authorizations, variances, approvals, accreditations and certificates of occupancy (the "**Permits**") relating to, or used in connection with the operation of, the Facility and the Facility Real Property, or relating to the use, operation or enjoyment of the Facility Assets including without limitation the Permits listed on **Exhibit A-1**.

(vii) Personal Property Leases. All right, title, and interest of the County or the Corporation in, to, and under the personal property leases (the "**Leases**") listed on **Exhibit A-1**, that are specifically accepted and assumed by Purchaser in writing and all rights (including rights of refund and offset), privileges, deposits, claims, causes of action, and options in favor of the County relating or pertaining to the Leases or any thereof.

(viii) Contracts. To the extent specifically accepted and assumed by Purchaser in writing, all right, title, and interest of the County in, to and under the contracts and agreements listed on **Exhibit A-1**, and all rights (including rights of refund and offset), privileges, deposits, claims, causes of action, and options in favor of the County or the Corporation relating or pertaining to such contracts and agreements or any thereof (collectively, the "**Assumed Contracts**").

(ix) Books and Records. Copies of all books, records of the County or the Corporation of whatever nature and wherever located that relate to the Facility Assets or the operation of the Facility and that are necessary or useful for Purchaser's operation of the Facility after the Closing Date, including without limitation all financial and accounting records, employee and payroll records and all books and records relating to the purchase of materials, supplies, and services, product research and

development, the manufacture and sale of products, and dealings with customers, vendors, and suppliers of the Facility, and including, to the extent assignment is permitted by any third party owner thereof, computerized books and records and other computerized storage media and the software (including documentation and object and source codes) used in connection therewith.

(x) Patient and Supplier Data. To the extent permitted by law, all patient lists, data and records, vendor lists and vendor data, supplier lists and supplier data, and sales and promotional material and other sales related material relating to, or used in connection with the operation of, the Facility.

(xi) Surveys, Maps, and Diagrams. All surveys, maps, and building and machinery diagrams and plans in the possession of the County and/or the Corporation relating to the Facility Assets.

(xii) Deposits. All right, title, and interest in and to resident security deposits.

(xiii) Other Rights. All rights, claims, and causes of action of the County or the Corporation against third parties (including the County's predecessors in title to the Assets) in respect of the Facility or the Facility Assets for claims arising after the Closing Date, including without limitation insurance claims, unliquidated rights under manufacturers' and vendors' warranties, rights of recovery, set offs, and credits.

(xiv) Warranty of Claims. All rights, claims, and causes of action of County under or pursuant to all warranties, representations, indemnifications, hold harmless provisions, and guarantees made by suppliers, licensors, manufacturers, contractors, and others (including the County's predecessors in title to the Facility Business Assets) in respect of the Facility or the Facility Assets.

(xv) Insurance Proceeds. With respect to claims made for events occurring on or after the date hereof but prior to the Closing, all insurance proceeds from all insurance policies and rights thereto derived from loss, damage or destruction of or to the Facility Real Property and improvements and personal property constituting Facility Assets, to the extent not utilized by the County or Corporation prior to the Closing Date to repair or replace the lost, damaged or destroyed items.

(xvi) All menus, policy and procedures manuals, operating manuals, marketing materials, trade secrets and confidential know-how and goodwill.

(xvii) All other assets, properties, rights, business and tangible personal property of every kind and nature owned by the County and/or the Corporation on the Closing Date, known or unknown, fixed or infixed, choate or inchoate, accrued, absolute, contingent or otherwise, whether or not specifically referred to in this Agreement specifically and primarily relating to the Facility and necessary to the operation thereof.

Nothing in this Agreement shall be construed as an attempt or agreement to assign, transfer, sublease or sublicense any Permit, Lease, or Contract which cannot be assigned, transferred, subleased or sublicensed without the consent or waiver of the party or parties thereto unless such consent or waiver shall have been obtained. The Corporation and the County shall use all reasonable efforts to obtain the consents and waivers of any other party required to assign, convey, settle, deliver and transfer the Facility Business Assets to the Operator. In the event that any such consent or waiver is not obtained, then the Corporation and the County, as applicable, shall provide the Operator with all of the benefits enjoyed by the Seller or the County, as applicable, under any such permit, lease or contract, and the Operator shall perform all of the obligations under any such permit, lease or contract.

Section 2.3 Excluded Assets. Notwithstanding any statement or provision contained in this Agreement to the contrary, the following assets are not Facility Business Assets and are hereby expressly excluded from such purchase and the definition of the term "Facility Business Assets" (collectively, the "**Excluded Assets**"):

(a) cash and cash equivalents as of the Closing Date, including investments in marketable securities, certificates of deposit, bank accounts, temporary investments, and the prepaid expenses and deposits as of the Closing Date;

(b) all accounts receivable arising out of or relating to all periods ending prior to the Closing Date, whether or not reflected on the Financial Statements, including all accounts receivable arising from the rendering of services and provision of medicine, drugs and supplies to patients at the Facility prior to the Closing Date;

(c) all personal property and possessions of residents of the Facility including but not limited to any amounts held by the County as the operator for the benefit of the residents;

(d) all claims, rights, interests and proceeds (whether received in cash or by credit to amounts otherwise due to a third party) with respect to amounts overpaid by County to any third party with respect to periods prior to the Closing Date, and rights to settlements and retroactive adjustments, if any, whether arising under a cost report of County or otherwise, for cost reporting periods ending at or prior to the Closing Date, whether open or closed, arising out of or relating to County's arrangements with any payor;

(e) all intercompany accounts of County, the Corporation and their affiliates;

(f) all inventory, prepaid expenses and other personal property assets disposed of, expended or exhausted prior to the Closing Date in the ordinary course of business and items of equipment and other personal property assets transferred or disposed of prior to the Closing Date in the ordinary course of business and in a manner expressly permitted in this Agreement and/or the Transition Agreement;

(g) all records or other materials that County, Corporation or theirs affiliates are required by law to retain in its possession or prohibited by law from transferring, assigning or disclosing, and all records related to the Excluded Assets or the Excluded Liabilities, as well as charter documents, minute books, stock ledgers, tax identification numbers, books of account and

other constituent records relating to the organization of the Facility, provided that the County and the Corporation shall allow Purchaser access thereto during normal business hours to any records set forth herein and Purchaser shall be permitted to make copies thereof subject to the Purchaser's execution of a confidentiality and non-disclosure agreement and necessary to the transition and/or operation of the Facility Business Assets;

(h) all manuals, policies and information to the extent that it does not pertain to the operations of the Facility;

(i) rights of payment (including IGT Payments) or for the recovery of money available to or being pursued by County at the Closing Date, that arise out of the operations of the Facility or the Facility Assets prior to the Closing Date, whether or not accrued and whether or not disclosed, and all rights and defenses in respect of indebtedness and other obligations not assumed by Operator and/or Real Property Purchaser hereunder unless as otherwise set forth in Section 2.1;

(j) rights to tax refunds or claims under or proceeds of insurance policies (except as set forth in Section 2.1(b)(xvi) or Section 5.1) related to the Facility or the Facility Assets resulting from periods prior to the Closing Date, and the right to pursue appeals of the same;

(k) the computers, computer software and intellectual property not used and/or located at the Facility as set forth on **Exhibit 2.3(k)** and all assets owned by tenant county agencies (i.e. the Orleans County Public Health Department, the Orleans County Elections Office, the Orleans County Sheriff's Office and the Orleans County Computer Services Department) not related to the operation of a nursing home facility. Information Technology equipment that is stored and operated within the building as part of the Orleans County Wide Area Network shall remain the exclusive property of Orleans County;

(l) other than the intellectual property described in **Section 2.1(b)(iv)** and the trade names set forth on **Exhibit A-1**, all trade names, trademarks and service marks (or variations thereof), copyrights, symbols, logos, domain names, email addresses and any other business names that are proprietary to County, all goodwill associated therewith, and all applications and registrations associated therewith, together with any promotional material, stationary, supplies or other items of inventory bearing such names or symbols or abbreviations or variations thereof as set forth on Schedule 2.3(l);

(m) all employee benefit plans and funds and accounts of all employee retirement, deferred compensation, health, welfare or benefit plans and programs, and any contracts or agreements related thereto, and any Facility Asset that would revert to the employer upon the termination of any employee benefit plan, including assets representing a surplus or overfunding of any employee benefit plan;

(n) the electronic funds transfer accounts of the Facility into which payments are made on account of patient accounts receivable and all information necessary to access such accounts. Notwithstanding the foregoing, to the extent that any payments relating to services rendered on and after the Closing Date are paid into the foregoing accounts, the same shall be the

property of Purchaser and held in trust for Purchaser and transferred to Purchaser within 5 days of receipt;

(r) accrued payroll and taxes relating thereto; and

(s) rights that accrue to County under all of County's contracts and agreements other than the Leases and the Contracts.

Section 2.4 Post Closing Rights to Access Facility Books and Records. The Corporation and the County and/or agents of the Corporation or the County shall have reasonable access during normal business hours and in accordance with reasonable policies and procedures established by the Operator to maintain the integrity of the same, to books and records of the Facility and operations thereof maintained by the Purchaser including those relating to accounts receivable existing as of or prior to the Closing Date, for a minimum period of two (2) years following the Closing, to allow the County, at the County's expense, to audit and collect all amounts payable (including, but not limited to IGT Payments except as may otherwise be set forth in Section 2.1 hereof) to the County in connection with the County's operation of the Facility through the Closing Date.

Section 2.5 Acquisition Price for Facility Assets and Adjustment for Expenses.

(a) With respect to the conveyance of the Facility Real Property and the Facility Business Assets to the Real Property Purchaser and the Operator, respectively, the Real Property Purchaser and the Operator shall pay the Acquisition Price to the Corporation. The Acquisition Price shall be a total of SEVEN MILLION EIGHT HUNDRED THOUSAND DOLLARS ($7,800,000.00), subject to adjustment as set forth in Article V, and other good and valuable consideration set forth in this Agreement. Payment of the Acquisition Price shall be made by bank check, attorney trust check, or wire transfer, as follows:

(i) Non-Refundable Deposit at Signing. Purchaser shall tender to the Escrow Agent the amount of SEVEN HUNDRED EIGHTY THOUSAND ($780,000.00) within two (2) business days of the execution and delivery of this Agreement as a deposit (the "Deposit"). The Deposit shall be offset by release to Seller by the Purchaser of the $150,000.00 in certified funds tendered by Purchaser at time the proposal was submitted.

(ii) Disbursement of Deposit. Seller shall cause the Deposit to be held by the Escrow Agent under the terms of the Escrow Agreement attached hereto as **Exhibit 2.5(a) (the Escrow Agreement")**. The Deposit (in all events net of the Bid Deposit) shall be refundable to the Purchaser only (i) if Seller, the County or the Corporation fails or is unable to perform or undertake obligations pursuant to this Agreement or the Transition Agreement; or (ii) in accordance with Article V hereof if applicable.

(iii) Remainder. After applying the Deposit, the remaining amount of the Acquisition Price, plus or minus any adjustments, shall be paid by the Purchaser to the Seller in immediately available funds, by certified check, bank check, or electronic wire transfer to Seller's designated bank account on the Closing Date.

(b) As of the Closing, expenses of a recurring nature that are incurred in connection with the Facility in the ordinary course of business, including those set forth below, shall be prorated in accordance with generally accepted accounting principles, so that all such expenses for periods on or prior to the Closing shall be for the account of the Corporation (paid by the County under the Leaseback Agreement), and all such expenses for periods after the Closing shall be for the account of the Operator and/or Real Property Purchaser and any such adjustments shall be added or deducted from the Acquisition Price, as the case may be.

(i) Current municipal water and sewer charges, if any, for the Facility Real Property shall be apportioned between the Purchaser (on the one hand) and the Corporation (on the other hand) as of the Closing.

(ii) The full amount of all unpaid assessments for municipal improvements, if any, including without limitation, any assessments that are payable in installments of which the first installment is due or payable on or prior to the Closing, shall be deducted from the Acquisition Price. The amounts of any unpaid assessments for municipal improvements, if any, including without limitation, any assessments that are payable in installments due or payable after the Closing shall be apportioned as of the Closing. Notwithstanding the foregoing, to the extent such installments relate to the period of time prior to the Closing Date, all such amounts shall be charged to Seller without regard to when they are due.

(iii) All amounts prepaid or payable under the leases, contracts, accounts and franchises being transferred hereunder shall be apportioned as of the Closing.

(iv) Any and all roll-back taxes shall be the sole responsibility of the Purchaser.

(v) In the event that any of such items cannot be determined at or prior to Closing the parties agree to adjust such items as soon as determinable after Closing, which obligation shall survive Closing.

Section 2.6 Real Estate and Other Taxes. Purchaser acknowledges that the Facility Real Property is currently wholly exempt from real property taxes (Roll Section 8) and that upon transfer of title to the Real Property Purchaser at the Closing Date, the taxable status of the Facility Real Property conveyed areas shall be determined in accordance with Section 520 of the New York Real Property Tax Law ("**RPTL**"). Purchaser further acknowledges that a pro rata tax may be assessed by the applicable assessor as of the Closing Date pursuant to RPTL Section 520 and that the Real Property Purchaser shall be responsible for all real estate taxes assessed against the Facility Real Property as of and after the Closing. Purchaser shall be solely responsible for payment of any and all taxes associated with the transfer of the Facility Business Assets from County and/or Corporation to Purchaser. To the extent applicable, the Operator shall comply with the provisions of Section 1141(c) of the Tax Law, and the regulations promulgated thereunder, pertaining to the sale of assets in bulk, as same are applicable to the transfer of the Facility Business Assets. Pursuant to Section 1141(c) of the Tax Law of the State of New York, utilizing Form AU-196.10 or such other form as may be required, Operator shall notify the New York State Department of Taxation and Finance by registered mail of the proposed sale and of the

price, terms, and conditions thereof (utilizing such forms as may be required or requested by the applicable Governmental Body).

Section 2.7 Allocation of Purchase Price. Operator, Real Property Purchaser and Seller agree to allocate the Purchase Price in accordance with the allocation set forth within Exhibit B, hereto, to be completed prior to closing upon mutual agreement of the Parties, and made a part hereof, to be bound by such allocation, to account for and report the purchase and sale of the Facility Assets contemplated hereby for federal and state tax purposes in accordance with such allocations, and not to take any position (whether in tax returns, tax audits, or other tax proceedings), that is inconsistent with such allocations without the prior written consent of the other Party. In this regard, the Parties agree that, to the extent required, they will each properly prepare and timely file form 8594 in accordance with Section 1060 of the Internal Revenue Code, as amended (the "Code").

Section 2.8 Survey, Title and Environmental Report.

(a) Survey. Seller has delivered to Purchaser all surveys in its possession of the Facility Real Property. If the description of the Facility Real Property set forth on the Survey is not the same as the description used in this Agreement, the foregoing surveyed legal description shall be subject to Seller's approval, not to be unreasonably withheld, conditioned or delayed. Any costs associated with the Survey incurred by Seller shall be reimbursed by Purchaser at Closing.

(b) Title. Seller shall provide Purchaser with a title insurance commitment ("**Title Commitment**") in a form reasonably acceptable to Purchaser, within thirty (30) days of contract execution subject to the Permitted Encumbrances and the subdivision of the real property of which the Facility Real Property is a part. Seller covenants to cure, at or prior to Closing, all objections that may be satisfied by the payment of a fixed sum of money, including, without limitation, deeds of trust, mortgages, municipal violations, or statutory liens (collectively, "**Monetary Encumbrances**"), and Seller's failure to cure such objections shall be satisfied at Closing by deducting from the amount due Seller the fixed sum of money required to satisfy such objections as determined by Purchaser in its reasonable discretion or, alternatively, should Seller be unable to satisfy such Monetary Encumbrances, to terminate the Agreement and receive a refund of the Deposit.

(c) Environmental Report. Seller has provided Purchaser with a Phase I Environmental Site Assessment Report prepared by LaBella Associates, P.C. dated December, 2013.

Section 2.9 Easements and Lease Amendments.

(a) Easements. To the extent necessary, in either party's reasonable discretion, as soon as practicable but in no event later than thirty (30) days after contract execution, Seller, the County and the Purchaser shall negotiate in good faith and each execute and deliver easements in proper form for recording in the Orleans County Clerk's Office (the "**Reciprocal Easement Agreement**" or "**REA**") for the following: (i) vehicular and pedestrian ingress and egress from the Facility Real Property to public rights of way over the

existing roadways; (ii) all necessary utility easements and connection rights to existing or proposed utilities benefitting the Facility Real Property, including any required easements for electric, gas, water, communication, public sewerage and storm water drainage. All Easements shall be designed with appropriate widths to accommodate access for repairs and maintenance and shall otherwise comply with applicable laws. All Easements shall be effective as of the Closing.

(b) As soon as practicable but not later than thirty (30) days prior to closing, Seller and the County shall have amended the Lease Agreement ("**Amended and Restated Lease Agreement**") and Leaseback Agreement ("**Amended and Restated Leaseback Agreement**") to include the terms described in Section 2.1.

Section 2.10 Brokerage. Purchaser warrants and represents to Seller that Purchaser has not dealt with any broker, agent or other party who might be deemed to be entitled to a commission or finder's fee in connection with the transactions contemplated under this Agreement. Seller represents and warrants that it has engaged Marcus & Millichap ("**Broker**"), to serve as Broker to Seller, and Seller shall pay Broker's total commission or fee, which shall relate to the Acquisition Price for all Facility Assets subject of this Agreement. The Seller and the County each represent and warrant that they have not dealt with any broker, agent or other party who might be deemed to be entitled to a commission or finder's fee in connection with the transactions contemplated under this Agreement other than the Broker. Purchaser will indemnify, defend and hold harmless Seller from and against any claim for a commission or finder's fee made by any other party by, through or under Purchaser, and Seller will indemnify, defend and hold harmless Purchaser from and against any claim for a commission or finder's fee made by any party by, through or under Seller, including Broker. This Article shall survive the Closing or other termination of this Agreement.

Section 2.11 The Parties agree that the Seller shall remain responsible for all obligations, liabilities, debt claims and audits, known or unknown, arising from, or attributable to the operation of the Facility, the Facility Real Property, and the Facility Business Assets, for all periods up to and including the Closing Date and Purchaser shall be responsible commencing on the Closing Date and thereafter.

Section 2.12 DOH/PHHPC Jurisdiction and Jurisdiction of Other Governmental Body. The Parties understand and acknowledge that operation by Purchaser of the Facility requires the DOH and/or PHHPC to approve the issuance of a Certificate of Need ("**CON**") to the Operator to operate the Facility. The Operator shall be responsible for submitting an application for CON for a minimum of 120 beds with the Guarantors included as principals of the Operator, and shall use commercially reasonable efforts to diligently pursue, in good faith, to conclusion an application for CON and shall submit said application as soon as practicable but not later than thirty (30) days after the Contract Date and Operator shall use good faith efforts to keep Seller and County informed of all progress and actions taken in connection with the CON application and status of approval of same. Operator shall use all reasonable efforts and due diligence in the procurement of such approval and Seller and the County shall reasonably cooperate in such effort. The Corporation and County shall cooperate with the Operator in providing information that is reasonably required by the Operator in connection with the review and/or approval by the DOH and/or PHHPC of the Operator's application for a CON.

Section 2.13 Governmental Applications. Within forty-five (45) business days of the Contract Date or as soon as allowable under applicable law, regulation, or programmatic guideline, the Purchaser shall file all other applications as may be required by the State, the federal government, the local governments where the Facility is located, and/or any other governmental agency, department or political subdivision in order to obtain any other license or permit that may be required in order to operate the Facility; provided the Subdivision and similar land use approvals will be subject to Section 2.9; and provided further, any applications that by their nature cannot be filed until a condition precedent is met that is to occur in the future, said applications will be filed and pursued as soon as practicable.

Section 2.14 Executory Contracts. Within thirty (30) Business days of the execution of this Agreement, Purchaser shall provide written notice to Seller of all of Seller's executory contracts described in Exhibit A-1 which the Purchaser desires to accept (the "Assumed Contracts"). All contracts other than the Assumed Contracts and the Leases, shall remain the responsibility of Seller or the County, as applicable, and may be terminated pursuant to each contract's term at or prior to Closing Date.

Section 2.15 Rights and Obligations of Corporation and Purchaser. The rights and obligations of the Parties shall be only as expressly stated herein and shall not be expanded, modified, extended or in any way changed by any subsequent change in circumstances or federal, state, county or local, statutory or common law, except as expressly provided for herein by written agreement signed by all parties to this Agreement.

Section 2.16 Closing Deliverables.

(a) At the Closing, as a condition precedent to the obligation of the Operator or the Real Property Purchaser hereunder, the Purchaser shall have received the following (unless expressly waived in writing by the Operator or the Real Property Purchaser):

(i) Bill of Sale and Assignment and Assumption Agreement. A counterpart page, signed by Seller, to a Bill of Sale and Assignment and Assumption Agreement in the form reasonably acceptable to the parties to convey the Facility Business Assets in accordance with the terms of this Agreement;

(ii) Deed. A Bargain and Sale Deed ("Deed") with covenants against grantor's acts conveying insurable title to the Facility Real Property, free and clear of all liens, claims and encumbrances, except for Permitted Encumbrances. The Deed shall be duly executed and acknowledged by Seller or the County, as applicable, along with required recording forms TP-584 and RP-5217, and a customary affidavit of title duly executed and acknowledged by Seller and reasonably acceptable to the Title Company;

(iii) Easements. A counterpart page, signed by the County to each of the Easements, the form and substance of which shall comply with Section 2.9(a), along with the required recording forms TP-584.

(iv) Authorizing Resolutions. Resolution(s) of the Corporation authorizing the Corporation to execute this Agreement and the closing documents, which

shall be certified to be true, complete and un-amended copies by the Corporation that are in full force and effect as of Closing;

(v) Documentation and Material Regarding Facility Real Property. Any keys, existing plans, specifications, architectural and engineering drawings, utilities layout plan, manuals, service and maintenance logs, paid invoices and similar documents relating to the Facility Real Property, and other documentation used in the construction, alteration or repair of the Facility, to the extent within the Corporation's and/or the County's possession;

(vi) Section 1445 Certificate. A certificate of Seller warranting that it is not a foreign person as defined under Section 1445 of the Internal Revenue Code;

(vii) Physical Possession. Actual physical possession of the Facility;

(viii) Certificate of Representations and Warranties. A certificate, dated as of the Closing Date, signed by the Seller certifying that all of the representations and warranties made by the Seller in this Agreement are true, accurate and complete in all material respects as of the Closing;

(ix) Manuals. All instructions, manuals and warranties that relate to any equipment used at the Facility to the extent in Seller's possession;

(x) Legal Opinion. Harris Beach PLLC shall deliver to the Real Estate Purchaser its legal opinion, in form attached hereto as **Exhibit 2.16(xiv)**.

(xi) Other Documents. Such further documentation as the Operator or the Real Property Purchaser or its attorneys may reasonably request.

(b) At Closing, and as a condition precedent to the obligation of the Seller hereunder, the Operator and/or the Real Property Purchaser shall deliver to the Seller the following (unless expressly waived in writing by the Seller):

(i) Purchase Price; Deposit; Closing Payment. The Purchaser shall deliver the remaining amounts due of the Acquisition Price to the Seller in immediately available funds;

(ii) Bill of Sale, Assignment and Assumption Agreement. A signed counterpart page to the Bill of Sale and Assignment and Assumption Agreement in the form acceptable to the parties hereto;

(iii) Certificate of Representations and Warranties. A certificate, dated as of the Closing, signed by the Operator and the Real Property Purchaser certifying that all of the representations and warranties made by the Operator and the Real Property Purchaser herein are true, accurate and complete as of the Closing;

(iv) Organizational Documents. Copies of the certificate of formation and other organizational documents of the Operator and Real Property Purchaser,

certified true and correct as of the Closing, and a Certificate of Good Standing of the Operator and Real Property Purchaser from the jurisdiction in which it is organized, dated not more than 30 days prior to the Closing; and

(v) Other Documents. Such further documents as the Seller or their attorney may reasonably request.

(c) Closing Date for Operational Transition. In accordance with the Lease Agreement, the Corporation is required to give the County no less than Sixty (60) days' notice prior to terminating the County rights under the Lease Agreement. Accordingly, unless waived by the Corporation, the Operator and Real Property Purchaser shall provide at least Seventy (70), but not more than Ninety (90) days' written notice to the Corporation as to the date on which the CON Approval will be effective and correspondingly the date upon which the rights of the County under the Leaseback Agreement are to be terminated (the "**Closing Date for Operational Transition**"). Upon receipt of such notice, along with evidence that Purchaser has received a CON from DOH and PHHPC and has funds on hand sufficient to deliver the balance of the Acquisition Price as of the Closing Date for Operational Transition, the Corporation and Purchaser shall take all necessary actions to complete the transfers contemplated herein and/or assist in the changeover of operations at the Facility.

Section 2.17 Assumed Liabilities. As of the Closing Date and in connection with the conveyance of the Facility Assets to Purchaser, Purchaser agrees to assume, as of the Closing, the future payment and performance under the Assumed Contracts solely to the extent arising out of and relating to periods after the Closing Date, and not the result of any event or circumstance or breach under the Assumed Contracts, arising or accruing (with the passing of time or the giving of notice or both) before the Closing Date (collectively, the "**Assumed Liabilities**"). Except solely for the Assumed Liabilities, Purchaser shall not assume, shall not be liable for and shall have no obligation to pay or assume, any of County's, Seller's or any third party's liabilities or obligations, including any liability or obligation of County arising out of or relating to the Facility Assets, including the operation of the Facility, prior to the Closing Date.

Section 2.18 Excluded Liabilities. Except solely for the Assumed Liabilities, all of County and/or Seller's liabilities and obligations, including all liabilities arising out of or relating to the Facility Assets other than the Assumed Liabilities, shall remain the sole responsibility of, and shall be satisfied by, the County or Seller, including, without limitation, the following: (a) any liability, indebtedness, commitment, or obligation of County or Seller, whether known or unknown, fixed or contingent, recorded or unrecorded, currently existing or hereafter arising; (b) any liability or obligation arising out of or relating in any manner to the conduct or operation of the Facility prior to the Closing Date, including any overpayments made by Medicare or Medicaid for services rendered at the Facility prior to the Closing Date; (c) any liability or obligation arising out of or relating to the ownership or use of the Facility Assets prior to the Closing, whether (in any case) fixed or contingent, recorded or unrecorded, known or unknown, currently existing or hereafter arising, and whether or not set forth or described in the schedules hereto; (d) any violation of the Worker Adjustment and Retraining Notification Act or similar State laws (the "**WARN Act**") with respect to operation of the Facility as a result of the consummation of the transactions contemplated by this Agreement; or (e) any obligations

or liabilities with respect to any Excluded Assets (all of the foregoing, collectively, the "**Excluded Liabilities**").

ARTICLE III

[RESERVED]

ARTICLE IV

REPRESENTATIONS AND COVENANTS

Section 4.1 Representations of the Operator and Real Property Purchaser. The Operator and Real Property Purchaser hereby represent and warrant to the Corporation as follows:

(a) The Operator and Real Property Purchaser are a limited liability company organized and existing under, and governed by, the laws of the State of New York, and it is duly qualified to transact business in each and every jurisdiction where such qualification is required to enable the Operator and Real Property Purchaser to perform their obligations under the terms of this Agreement. No Act of Bankruptcy has been commenced by or against the Operator and Real Property Purchaser. The execution of this Agreement, and the performance of all obligations under this Agreement, have been authorized by all required action of the Operator and Real Property Purchaser, all as required by the Articles of Organization, Operating Agreement and Applicable Laws that regulate the conduct of the Purchaser's affairs. The execution of this Agreement and the performance of all obligations set forth herein do not conflict with and do not constitute a breach of or event of default under any Certificate of Incorporation or By-laws of the Operator and Real Property Purchaser, or any agreement, indenture, mortgage, contract or instrument to which the Operator and Real Property Purchaser is a party or by which the Operator and Real Property Purchaser is bound so that, upon execution hereof and upon satisfaction of the conditions herein contained, this Agreement constitutes the valid, legally binding obligations of the Operator and Real Property Purchaser, enforceable against the Operator and Real Property Purchaser in accordance with its terms, except to the extent that enforcement thereof is limited by applicable bankruptcy, insolvency, reorganization, moratorium or other laws relating to or limiting creditors' rights generally and the application of the general principles of equity.

(b) The Operator and Real Property Purchaser represents that they or their designees will possess at Closing all licenses and approvals required under Applicable Laws to undertake and carry out their respective obligations under this Agreement.

(c) The Purchaser reasonably expects that it will possess at the Closing funds sufficient to pay respective portions of the Acquisition Price for the purchase of the Facility Assets as set forth in this Agreement and shall provide evidence to the satisfaction of the Corporation (in a form and through a process reasonably acceptable to Purchaser that insures the confidential nature of the information) on October 31, 2014, and thereafter on each February 1, May 1, August 1, November 1 until the Closing.

(d) There is no action, suit or proceeding, at law or in equity, before or by any court or similar Governmental Body against the Operator and Real Property Purchaser wherein an unfavorable decision, ruling or finding would materially adversely affect the performance by the Operator and Real Property Purchaser of its obligations hereunder or the other transactions contemplated hereby, or that, in any way would materially adversely affect the validity or enforceability of this Agreement or any other agreement or instrument entered into by the Operator and Real Property Purchaser in connection with the transaction contemplated hereby.

(e) Purchaser has the ability to obtain funds in cash in amounts equal to the Acquisition Price by means of a combination of a private offering of membership interests and credit facilities or otherwise and will at the Closing have immediately available funds in cash which will be sufficient to pay the Acquisition Price and to pay any other amounts payable pursuant to this Agreement and to consummate the transactions contemplated by this Agreement.

(f) Neither the Operator and Real Property Purchaser, nor any of its respective principals or affiliates operates, controls, or manages any health care facilities in the State of New York except for those described in the RFP of the Guarantors (the "**Purchaser's Existing Facilities**"), and with respect to the Purchaser's Existing Facilities, to the best of the Purchaser's knowledge and belief, there have been no violations or enforcement actions that would cause the denial of the CON. None of the Purchaser's principals have a history of criminal convictions of the type that would preclude approval of the application for licensure in accordance with State law.

(g) Purchaser agrees that all persons who are residents of the Facility on the Closing Date shall continue to be residents after the Closing Date, and no resident shall be transferred to another facility without his or her express written consent while in good standing, unless medically necessary and then only as permitted by Department of Health and other applicable rules and regulations. Residents who may qualify for a lower level of care, and have a desire for transfer, will be assisted by the Purchaser to find a home in a quality setting. Residents' safety, dignity and psychosocial well-being will always be deciding factors for any discharge considerations.

(h) Prior to or contemporaneously with the Closing Date, Purchaser shall interview and consider the employment of any County Employee(s) employed by the County at the Facility who express an interest (through written application or other means provided by Purchaser) in being employed by Purchaser. The Purchaser intends to maintain feasible staffing levels and, to the extent former county employees are employed, said former county employee salaries and paid time off would not be reduced. Any new employees will be compensated with benefits and salary based upon years of experience and compatible with the fair market value.

(i) Operator agrees to continue a mentoring program with one or more of the school districts of Orleans County substantially similar to the existing program with the Albion School District and food service for Hospice Orleans.

(j) The Real Property Purchaser shall lease to the County those portions of the Facility currently utilized by the County for its board of elections and public health offices under a lease substantially similar to the Lease Agreement; provided the current triple net lease

shall be set at a gross lease payment (inclusive of taxes, insurances, utilities and any common area charges or maintenance or capital costs) of Ten Dollars ($10.00) per square foot per annum subject to annual renewal at the election of the County for up to five (5) years.

(k) Purchaser shall continue operations of the Facility as a skilled nursing facility under the name "The Villages of Orleans Health and Rehabilitation Center" for up to a ten (10) year period subsequent to the Closing Date.

Section 4.2 Representations of the Corporation. The Corporation represents and warrants to the Purchaser as follows:

(a) The Corporation is a domestic not-for-profit corporation organized and existing under, and governed by, the laws of the State of New York, and is duly qualified and has the power, authority, and legal right, to enter into and perform it obligations set forth in this Agreement.

(b) The execution, delivery, and performance of this Agreement (i) has been duly authorized by the governing body of the Corporation, (ii) does not require any consent, approval or referendum of voters not otherwise obtained, and (iii) will not violate any Applicable Laws applicable to the Corporation or any provisions of the County Authorizing Resolution.

(c) The execution of this Agreement, and the performance of all obligations set forth herein do not conflict with, and will not, nor with the passage of time or the giving of notice, or both, constitute a breach of or event of default under any charter, ordinances or resolutions of the Corporation or any agreement, indenture, mortgage, trust, contract or instrument of Applicable Laws to which the Corporation is a party or by which the Corporation is bound. This Agreement has been duly executed and delivered and constitutes a legal, valid and binding obligation of the Corporation, enforceable in accordance with its terms, except to the extent that the enforcement thereof is limited by any applicable bankruptcy, insolvency, reorganization, moratorium or other laws relating to or limiting creditor' rights generally and the application of general principles of equity.

(d) There is no action, suit or proceeding, at law or in equity, pending before or by any court or governmental authority against the Corporation, or to the best of the Corporation's knowledge, threatened, where in an unfavorable decision, ruling or finding would materially adversely affect the performance by the Corporation of its obligations hereunder or the other transactions contemplated hereby, or which, in any way, would adversely affect the validity or enforceability of this Agreement, or any other agreement or instrument entered into by the Corporation in connection with the transactions contemplated hereby. The Corporation is not subject to any writ, judgment, decree, injunction, settlement or order with respect to the Facility Assets. Notwithstanding, see Index No. 13-41032, *CSEA, et. al., v. Orleans County Legislature, et. al.*

(e) The Facility Business Assets are as of the Contract Date, and will be as of the Closing Date, (1) located at the Facility, and (2) free and clear of any claim, lease, mortgage, security interest, conditional sale agreement or other title retention agreement, restriction or lien or encumbrance.

(f) Purchaser's Right to Observe Business. The Purchaser shall have access rights to the Facility prior to the Closing upon reasonable prior notice.

(g) To the best of Corporation's knowledge, there are no audits, active suits or proceedings that (i) challenge the use of the Facility as a long-term healthcare facility with 120 licensed beds, (ii) challenge or seek to change the Facility Licensed Capacity, (iii) challenge or seek to change the conditions of operation of the Facility set forth in the Certificate of Need, or (iv) challenge the Facility's certification to participate in the Medicaid Program under Title XIX of the Social Security Act.

(h) To the best of Seller's actual knowledge without independent investigation, there are no restriction, or prohibitions on (or relating to) the Facility Assets that would inhibit, prohibit or materially affect the ability of the Purchaser to make use of such Facility Assets in the manner contemplated by the terms of this Agreement.

(i) Appropriate Actions. From and after the date hereof, Seller shall take any and all actions reasonably required to effectuate the transactions contemplated by this Agreement.

(j) Environmental Matters.

(i) To the best of Seller's actual knowledge without independent investigation, Seller has not received any written notice of alleged, actual or potential responsibility for, or any inquiry or investigation regarding, the presence or Release of any Hazardous Substance at the Facility Real Property, not otherwise in compliance with any applicable Environmental Law, which Hazardous Substances were allegedly manufactured, used, generated, processed, treated, stored, disposed or otherwise handled at, or transported or released from the Facility Real Property. To the best of Seller's actual knowledge without independent investigation, Seller has not received any written notice of any other claim, demand or action by any individual or entity alleging any actual or threatened injury or damage to any person or entity, property, natural resource or the environment arising from or relating to the presence or Release of any Hazardous Substances, not otherwise in compliance with any applicable Environmental Law at, on, under, in, to or from the Facility Real Property or in connection with any operations or activities of Seller thereat.

(ii) For purposes of this Agreement, the term "Environmental Laws" shall mean any all applicable federal, state and local land use, zoning, health, chemical use, air quality, water quality, safety and sanitation laws relating to the protection of the environment or governing the use, storage, treatment, generation, transportation, processing, handling, production or disposal of any Hazardous Substances. Without limiting the generality of the foregoing, Environmental Laws shall include the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, the Toxic Substances Control Act, as amended, the Hazardous Materials Transportation Act, as amended, the Resource Conservation and Recovery Act, as amended, the Clean Water Act, as amended, the Safe Drinking Water Act, as amended, the Clean Air Act, as amended, the Occupational Safety and Health Act, as amended, and all similar and/or analogous laws enacted, promulgated or lawfully issued by any Governmental Entity.

(iii) For purposes of this Agreement, the term "Hazardous Substances" shall mean any pollutants, contaminants, substances, chemicals, carcinogens, wastes, dangerous wastes, or any ignitable, corrosive, reactive, toxic or other hazardous substances or materials, whether solids, liquids or gases (including, but not limited to, petroleum and its derivatives, PCBs, asbestos, radioactive materials, waste waters, sludge, slag and any other substance, material or waste), as defined in or regulated by any Environmental Laws or as finally determined by any Governmental Entity.

(iv) For purposes of this Agreement, the term "Release" shall mean any spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, migration, dumping or disposing into the environment not otherwise in compliance with any applicable Environmental Law.

(v) Purchaser acknowledges that it will be conducting its own environmental due diligence and has received a copy of the Phase I Environmental Report obtained by Corporation.

ARTICLE V

CASUALTY AND CONDEMNATION

Section 5.1 Casualty. If at any time prior to Closing there is a Material Issue that occurs with respect to any of the Facility Assets as a result of fire or any other casualty ("Casualty"), Seller shall give written notice ("Casualty Notice") thereof to the Purchaser. If the Facility Assets are the subject of such a Casualty, Purchaser shall have the option to: (i) terminate this Agreement upon written notice to Seller, if Seller is unwilling or unable to repair the damage to Purchaser's reasonable satisfaction within a reasonable period of time or provide funds or a credit to the Acquisition Price to provide funds for Purchaser to repair the damage, in which event the Deposit, to the extent paid by the Purchaser, shall be returned to Purchaser, and, thereafter, this Agreement shall be deemed to be null, void and of no further force and effect; or (ii) accept title to the Facility Assets with no adjustment of the Acquisition Price and upon the Closing, Seller and/or the County shall assign, transfer and set over to Purchaser all of the right, title and interest of Seller and/or the County in and to the proceeds of any insurance with respect to the Facility Assets paid between the date of this Agreement and Closing and any deductible payable by Seller (less amounts incurred by Seller in performing necessary repairs to protect the Facility Assets), and all unpaid claims and rights in connection with losses to the Facility shall be assigned to Purchaser at Closing without in any manner affecting the Acquisition Price. Risk of loss shall pass to Purchaser on the Closing Date, provided that, to the extent applicable, the County shall remain liable under the Leaseback Agreement, as amended.

In the event an immaterial part of the Facility Assets are damaged or destroyed as a result of a Casualty and it is not a Material Issue, Seller shall promptly contract for and commence repairs and complete such repairs as soon as practicable and the parties shall proceed with closing as set forth herein without repair of the casualty damage and Purchaser shall receive a credit against the Purchase Price in the amount of the damage estimate, as reasonably determined by Seller and Purchaser.

Section 5.2 Condemnation. If either: (i) all of the Facility Real Property; or (ii) a material portion of the Facility Real Property; is taken between the date of this Agreement and the date of Closing by the exercise of the power of eminent domain by any local, state, or federal body, Seller shall notify the Purchaser and the Purchaser shall have the option to: (i) terminate this Agreement upon written notice to Seller, in which event the Deposit shall be returned to Purchaser, and, thereafter, this Agreement shall be deemed to be null, void and of no further force or effect; or (ii) complete Closing at the full Purchase Price, and Seller shall allow a credit to Purchaser at Closing equal to the amount of condemnation proceeds actually paid to Seller prior to Closing and shall assign to the Purchaser all of Seller's rights to any unpaid claims in connection with the eminent domain award or compensation. If there is an immaterial taking of the Property, the parties shall be obligated to close, and at Closing, Seller shall allow a credit to the Purchaser equal to the amount of condemnation proceeds actually paid to Seller prior to Closing, and Seller shall assign to the Purchaser all of Seller's rights to any unpaid claims in connection with the eminent domain award or compensation.

For purposes of this section, a Material Issue shall also include damage that prevents the Facility Real Property from being used as skilled nursing facility with 120 licensed beds.

ARTICLE VI

BREACHES AND DEFAULTS

Section 6.1 Breach of Covenants, Obligations, Representations or Warranties by Purchaser. If at any time subsequent to the Contract Date and prior to the Closing, except for such covenants and conditions that expressly survive the Closing, which shall continue after the Closing, (a) the Purchaser shall breach any material obligation, covenant or warranty made by it herein, or (b) any material representation made by the Purchaser herein shall be (or prove to be) false in any material respect, then, upon the Seller providing written notice thereof to the Purchaser, the Purchaser shall proceed with due diligence and dispatch to take all such actions as shall reasonably be required to cure such breach, and the Purchaser shall continue to take all such action until such breach is cured.

Section 6.2 Events of Default by Purchaser. Subject to the provisions of Section 6.1 hereof, the occurrence of any one or more of the following which is not cured within thirty (30) days of either the occurrence or written notice thereof shall constitute an Event of Default by the Purchaser hereunder provided however, that if the Purchaser is diligently pursuing such cure, and if in the reasonable judgment of the Seller, there is a reasonable likelihood that such breach will be cured within such thirty (30) day period, then failure to cure such breach shall not be considered to be an Event of Default until the 90th day after such breach has occurred or such written notice has been provided, whichever is later:

(a) Failure by the Purchaser (within thirty (30) days of either the occurrence or written notice of any event described in Section 6.1 above, whichever is later), to cure such breach; or

(b) Any Act of Bankruptcy on the part of the Purchaser has occurred prior to satisfaction of the terms and conditions of this Agreement;

(c) Failure to provide the Corporation with timely reports of availability and proof of funds as required pursuant to Section 4.1 (e) hereof; or

(d) In the event that Purchaser is unable to consummate the transactions contemplated in this Agreement because it is unable to pay the Acquisition Price to the Seller as provided herein, unless such failure is due to an Event of Default by Seller.

Section 6.3 Remedies of the Corporation. Except as otherwise expressly provided in this Agreement, the remedies for the occurrence of an Event of Default set forth under Section 6.2 hereof shall be, at the option of the Corporation, a suit seeking specific performance by the Purchaser of the provisions of this Agreement and injunctive relief. All rights and remedies of the Corporation under this Agreement are cumulative of and not exclusive of, any rights or remedies otherwise available, and the exercise of any such rights or remedies shall not bar the exercise of any other rights or remedies.

Section 6.4 Breach of Covenants, Obligations, Representations or Warranties by the Corporation. If at any time subsequent to the Contract Date and prior to the Closing, except for such covenants and conditions that expressly survive the Closing, which shall continue after the Closing, (a) the Corporation shall breach any material obligation, covenant or warranty made by it herein, or (b) any material representation made by the Corporation herein shall be (or prove to be) false in any material respect, then, upon the Purchaser providing written notice thereof to the Corporation, the Corporation shall proceed with due diligence and dispatch to take all such actions as shall reasonably be required to cure such breach, and the Corporation shall continue to take all such action until such breach is cured or alternatively the Corporation may terminate the Agreement and return the Deposit.

Section 6.5 Events of Default by Corporation. Subject to the provisions of Section 6.4 hereof, the occurrence of any one or more of the following which is not cured within thirty (30) days of the occurrence or written notice thereof, whichever is later, shall constitute an Event of Default by the Corporation hereunder provided however, that if the Corporation is diligently pursuing such cure, and if in the reasonable judgment of the Purchaser, there is a reasonable likelihood that such breach will be cured within ninety (90) days, without diminution in value (consistent with the definition of Material Issues) period, then failure to cure such breach shall not be considered to be an Event of Default until the 90th day after such breach has occurred or such written notice has been provided, whichever is later, and provided that, in all events, Extension Fees are paid:

(a) Failure by the Corporation (within thirty (30) days of written notice of any event described in Section 6.4 above), to cure such breach; or

(b) If the Corporation has failed to exercise its rights to terminate this Agreement and enters into a binding contract with a third party to sell the Facility Assets between the Contract Date and Closing Date; provided the Purchaser is not in default hereunder; and provided further either party reserves its rights to terminate under Section 2.1 herein.

Section 6.6 Remedies of Purchaser for Event of Default by Corporation. The remedies for the occurrence of an Event of Default set forth under Section 6.5 hereof shall be, at the option

of the Purchaser, either (a) to file a suit seeking specific performance by the Corporation or the County, as applicable of the provisions of this Agreement and/or injunctive relief, (b) to file a suit seeking a declaratory judgment terminating this Agreement, or (c) to terminate this Agreement by written notice to Seller at which time the Deposit shall be promptly returned to Purchaser. All rights and remedies of Purchaser under this Agreement are cumulative or and not exclusive of, any rights or remedies otherwise available, and the exercise of any such rights or remedies shall not bar the exercise of any other rights or remedies and Purchaser's remedies may be pursued simultaneously or in succession.

Section 6.7 Pendent Disputes. Notwithstanding anything contained in the Agreement to the contrary, if there shall be a dispute concerning the right of a party to terminate this Agreement, the Purchaser shall continue to pursue its CON application.

Section 6.8 Non-waiver. No delay or omission to exercise any right or power accruing upon the occurrence of any Event of Default shall impair any such right or power or shall be construed to be a waiver of any such Event of Default or acquiescence therein, and every such right and power may be exercised from time to time and as often as may be deemed expedient by the nonbreaching party in its sole discretion. No waiver of the occurrence of any Event of Default hereunder, whether by the Purchaser or the Corporation, shall extend to or shall affect any subsequent Event of Default or shall impair any rights or remedies consequent thereto.

Section 6.9 Indemnification.

(a) Indemnification by Purchaser. Purchaser agrees to protect, indemnify, defend and hold the Corporation and the County, and its officers, members, employees, and agents, successors and assigns, free and harmless from and against any and all claims, debts, liabilities, obligations, losses, fines, penalties, judgments, assessments, damages, costs and expenses (including but not limited to reasonable attorneys' fees and expenses), liens and encumbrances accruing, resulting from and/or directly arising out of (i) any breach or violation of any representation, warranty, covenant, stipulation, agreement or certification by Purchaser set forth in this Agreement or in any document delivered hereunder, provided that such breach or violation has been determined to have occurred by a court of competent jurisdiction, or; (ii) the breach by Purchaser of any other term or provision of this Agreement, provided that such breach has been determined to have occurred by a court of competent jurisdiction; (iii) any damages to the Facility Assets caused by the negligence, gross negligence or intentional acts of Purchaser, its agents, employees, independent contractors, officers or directors (it being agreed that neither Seller, the County nor any of their employees or agents constitutes an agent, employee, independent contractor, officer or director of Purchaser), prior to Closing; or (iv) any facts or events occurring after the Closing and connected with the Facility Assets, the activities of Purchaser or the operations of the Facility; provided, however, the indemnity shall not apply to any liability arising in whole or in part from a breach of this Agreement by Seller or the County, provided that such breach has been determined to have occurred by a court of competent jurisdiction or other act or omission by Seller or the County occurring on or before the Closing and shall also not apply to any act or omission of the County, whether pursuant to the Leaseback Agreement as amended, or otherwise. Notwithstanding anything contained herein to the contrary,

this indemnification shall only be for third party claims and consequential damages shall not be recoverable.

(b) Indemnification by Corporation. The Corporation, agrees to protect, indemnify, defend, and hold Purchaser and its members, officers, trustees, affiliates, agents, legal representatives, successor and assigns, and each of them, free and harmless from and against any and all claims, debts, liabilities, obligations, losses, damages, fines, penalties, judgments, assessments, damages, costs and expenses (including but not limited to reasonable attorneys' fees and expenses), liens and encumbrances accruing based upon, resulting from or directly or indirectly arising out of (i) any breach or violation of any representation, warranty, covenant, stipulation, agreement or certification by the Corporation or the County set forth in this Agreement or in any document delivered hereunder, provided that such breach or violation has been determined to have occurred by a court of competent jurisdiction; or (ii) the breach by Seller or the County of any other term or provision of this Agreement, provided that such breach or violation has been determined to have occurred by a court of competent jurisdiction; or (iii) any facts or events occurring prior to the Closing and connected with the Facility Assets, the activities of Seller or the County or the operation of the Facility; or (iv) any Medicare or Medicaid claims concerning services rendered, facts or events occurring prior to the Closing; or (v) the Excluded Assets and the Excluded Liabilities; or (vi) any Material Issue, provided, however, that the indemnity shall not apply to any liability to the extent arising out of a breach of this Agreement by Purchaser, so long as such breach has been determined to have occurred by a court of competent jurisdiction; and provided further that with respect to claim made as described in (iv) of this Section 6.9(b), Purchaser shall direct requests for indemnification to the Corporation, attention Chief Executive Officer. In no event shall consequential damages be recoverable. Notwithstanding anything contained herein to the contrary, Seller shall hold Purchaser harmless for all third party claims related to the period prior to the Closing Date,

(c) Claims. Whenever any claim (each, a "Claim") for indemnification shall arise under this Section 6.9, other than a Third Party Claim (as such term is defined in Section 6.9(d) below), the Party seeking indemnification (the "Indemnitee") shall notify in writing the Party from which indemnification is sought (the "Indemnitor") of the Claim within thirty (30) days after Indemnitee becomes aware of the Claim's existence, specifying the factual basis for the Claim and the amount or an estimate (if known or reasonably determinable) of the liability that may arise therefrom. The Indemnitor and the Indemnitee shall use their good faith efforts to determine the existence and amount of any Liability associated with a Claim asserted during the thirty (30) day period following delivery of notice of the Claim to the Indemnitor (such period is referred to as the "Negotiation Period"). If the Claim is mutually agreed to be valid and the amount of the Liability is agreed to during the Negotiation Period, it shall be paid by the Indemnitor within thirty (30) days of the date of determination of the agreed amount of the Claim by the Indemnitor and Indemnitee (the "Determination Date"). If the Parties are unable to resolve the amount or manner of determination of any indemnity obligation owed under this Agreement, then, upon the termination of the Negotiation Period, any Party may commence an action to enforce the provisions hereof. In the event the Parties are unable to resolve any indemnification Claims and an Action is commenced, the prevailing Party will be entitled to attorney's fees. With respect to any Claim hereunder, after (i) any final decision, judgment or award shall have been rendered and the time to appeal therefrom has expired, (ii) a settlement shall have been consummated, or (iii) the Indemnitee and the Indemnitor shall have arrived at a

mutually binding agreement, the Indemnitee shall forward to the Indemnitor notice of any sums due and owing by the Indemnitor pursuant to this Agreement with respect to such matter. Notwithstanding anything to the contrary herein, no Indemnitee shall be entitled to indemnification hereunder in respect of any Loss to the extent caused by the negligence or willful misconduct of such Indemnitee or its Affiliates, members, directors, trustees, managers, officers, employees, agents, successors and assigns.

(d) Third Party Claims.

(i) In the event of a third party Claim or action (a "**Third Party Claim**"), the Indemnitee shall give the Indemnitor notice after the Indemnitee receives notice of a Third Party Claim and shall specify (if known) the factual basis for the Third Party Claim and the amount or an estimate (if known or reasonably determinable) of the liability that may arise therefrom. In each such case the Indemnitee agrees to give such notice to the Indemnitor within thirty (30) days of receipt by Indemnitee of such Third Party Claim; provided, however, that the failure of the Indemnitee to give such notice shall not excuse the Indemnitor's obligation to indemnify except to the extent that the Indemnitor has suffered damage or prejudice by reason of the Indemnitee's failure to give, or delay in giving, such notice.

(ii) If any Third Party Claim is made against an Indemnitee and the Indemnitee gives notice to the Indemnitor of such Third Party Claim, the Indemnitor may defend against the Third Party Claim with counsel of the Indemnitor's choice that is reasonably satisfactory to the Indemnitee if (1) within fifteen (15) days following the receipt of notice of the Third Party Claim the Indemnitor notifies the Indemnitee in writing that the Indemnitor will indemnify the Indemnitee from and against the entirety of any Losses the Indemnitee may suffer resulting from, relating to, arising out of, or attributable to the Third Party Claim, (2) the Indemnitor provides the Indemnitee with evidence reasonably acceptable to the Indemnitee that the Indemnitor will have the financial resources to defend against the Third Party Claim and pay, in cash, all Losses the Indemnitee may suffer resulting from, relating to, arising out of, or attributable to the Third Party Claim, (3) the Third Party Claim involves only money Losses and does not seek an injunction or other equitable relief that could possibly affect the Indemnitee, (4) settlement of, or an adverse judgment with respect to the Third Party Claim that is in the good faith judgment of the Indemnitee not likely to establish a precedential custom or practice materially adverse to the continuing business interests of the Indemnitee, and (5) the Indemnitor continuously conducts the defense of the Third Party Claim actively and diligently. The Indemnitor shall not consent to or approve the entry of any Order with respect to the Third Party Claim without the prior written consent of the Indemnitee (which consent shall not be withheld unreasonably, provided that it will not be deemed to be unreasonable for an Indemnitee to withhold its consent with respect to any finding of or admission (A) of any breach of any Applicable Law, (B) of any violation of the rights of any Person, or (C) which the Indemnitee believes could have a material adverse effect the Facility or on any other Action to which the Indemnified Party or its Affiliates are a party or to which Indemnitee has a good faith belief it may become a party). If the Indemnitor assumes the defense of an Action it will be conclusively established for purposes of this Agreement that the claims made in that Action are within the scope of and subject to the indemnification hereunder. If notice is given to the Indemnitor of the commencement of any Third Party Claim and the Indemnitor does not, within fifteen (15) days after Indemnitee's notice is given, give notice to the Indemnitee of Indemnitor's election to

assume the defense of such Third Party Claim, the Indemnitor will be bound by any determination made in such Action or any compromise or settlement effected by the Indemnitee made with the consent of the Indemnitor which consent shall not be unreasonably delayed or withheld.

(iii) Notwithstanding the foregoing, if an Indemnitee reasonably determines in good faith that there is a reasonable probability that a proceeding may adversely affect an Indemnitee other than as a result of monetary damages for which it would be entitled to indemnification under this Agreement or the Indemnitor is also a party to such proceeding and the Indemnitee determines in good faith that joint representation would be inappropriate, the Indemnitee may, by reasonable notice to the Indemnitor, assume the exclusive right to defend, compromise or settle with the consent of the Indemnitor, not to be unreasonably withheld, such proceeding at the expense of the Indemnitor under the scope of the indemnification hereunder, and the Indemnitor shall have the right to participate in the defense of such proceeding at Indemnitor's own expense.

ARTICLE VII
MISCELLANEOUS

Section 7.1 Governing Law; Dispute Resolution. This Agreement shall be governed by, and construed in accordance with, the laws of the State of New York in a State Supreme Court in the County. Notwithstanding anything herein to the contrary, the Parties may resolve any disputes which may arise among them through any available legal or equitable procedure. In addition, the Parties may, on a case-by-case basis, agree to submit any such dispute to a non-binding arbitration procedure in order to create a factual record which will be available for use by a court of competent jurisdiction in any subsequent action relating to such dispute. In all events, Purchaser shall continue to pursue its CON application.

Section 7.2 Further Assurances. Each party shall execute and deliver any instruments and perform any acts that may be necessary or reasonably requested in order to give full effect to the terms of this Agreement. Each party shall use all reasonable efforts to provide such information, execute such further instruments and documents and take such action as may be reasonably requested by the other Parties; provided however, that such actions are not inconsistent with the provisions of this Agreement and do not involve the assumption of obligations other than those which are provided for in this Agreement to carry out the intent of this Agreement.

Section 7.4 Relationship of the Parties. Except as otherwise explicitly provided herein, or by Applicable Laws, no party to this Agreement shall have any responsibility whatsoever with respect to services that are to be provided or contractual obligations that are to be assumed by any other party and nothing in this Agreement shall be deemed to constitute any party a partner, joint venture participant, agent or legal representative of any other party or to create any fiduciary relationship between or among the Parties.

Section 7.5 Waiver. The waiver by any party of a default or of a breach of any provision of this Agreement by the other Parties shall not operate or be construed to operate as a waiver of any subsequent default or breach. The making or the acceptance of a payment by

any party with knowledge of the existence of a default or breach shall not operate or be construed to operate as a waiver of any subsequent default or breach.

Section 7.6 Modification. Modifications, waivers or amendments of (or to the provision of) this Agreement shall be effective only if set forth in a written instrument signed by each party hereto after all corporate or other action regarding the authorization for such modification, waivers or amendments has been taken.

Section 7.7 Headings. The captions and headings in this Agreement are for convenience and ease of reference only and in no way define, limit or describe the scope or intent of this Agreement and such headings do not in any way constitute a part of this Agreement.

Section 7.8 Notices. Any notice or other communication which is required to be given hereunder shall be in writing and shall be deemed to have been validly given if delivered in person or mailed by certified or registered mail, postage prepaid, addressed as follows:

To the Corporation:	Orleans County Health Facilities Corporation 3 South Main Street Albion, New York 14411 Attn: Chief Executive Officer
With Copies to:	Harris Beach PLLC 99 Garnsey Road Pittsford, New York 14534 Attn: Shawn M. Griffin, Esq.
If to the Operator:	Comprehensive at Orleans LLC c/o Rosenbaum & Associates, P.C. 4 Canaan Circle South Salem, New York 10590 Attn: Tara Rosenbaum, Esq.
If to the Real Property Purchaser:	Telegraph Realty LLC c/o Rosenbaum & Associates, P.C. 4 Canaan Circle South Salem, New York 10590 Attn: Tara Rosenbaum, Esq.
With Copies to:	Rosenbaum & Associates, P.C. 4 Canaan Circle South Salem, New York 10590 Attn: Tara Rosenbaum, Esq.

Changes in the addresses to which such notices may be directed may be revised from time to time by any party by written notice to the other Parties.

Section 7.9 Successors and Assigns. This Agreement may not be assigned without the written consent of the Parties.

Section 7.10 As is No Representations or Warranties. Except as may otherwise be set forth in this Agreement, Purchaser acknowledges and agrees that neither Seller nor any agent or representatives of Seller have made, and Seller is not liable or responsible for or bound in any manner by any express or implied representations, warranties, covenants, agreements, obligations, guarantees, statements, information or inducements pertaining to the condition of the Facility Assets or any part thereof. Purchaser acknowledges, agrees, represents and warrants that it has had, and/or shall have had, the opportunity and has in fact, and/or shall have in fact, inspected the Facility Assets and all matters respecting the Facility Assets and is and/or shall be fully cognizant of the condition of the Facility Assets and that it has had, and/or shall have had, access to information and data relating to all of same as Purchaser has considered necessary, prudent, appropriate or desirable for the purposes of this transaction and that Purchaser and its agents and representatives have, and/or shall have had, independently inspected, examined, analyzed and appraised all of same. Purchaser acknowledges that Purchaser is and/or will be fully familiar with the Facility Assets and Purchaser agrees, except as may otherwise be set forth in this Agreement, the Transition Agreement, the Leaseback Agreement and/or the Lease Agreement to the contrary and subject to the representations therein, to accept the Facility Assets (including the structural and mechanical condition of the Facility Assets, the building, the structures and improvements situate thereon, the plumbing, heating, electrical and ventilation systems serving the Facility Assets and any other matter or thing whatsoever with respect thereto) "AS IS", with all faults, in its current condition, including all environmental matters except as set forth herein, subject to reasonable wear and tear. Seller shall maintain the Facility Assets in its current condition until Closing. Purchaser shall be responsible at its sole cost and expense to obtain and satisfy all required governmental or regulatory inspection, certificate or other such transfer requirements prior to Closing. Purchaser hereby assumes the risk that adverse past, present or future conditions may not be revealed in its inspection or investigation. Seller has in full force and effect liability and casualty insurance insuring the Facility Assets, as appropriate. Upon information and belief, there have been in force since the acquisition of the Facility Assets by the County policies of insurance or County self-insurance protecting the County against all losses and claims, and there have been no gaps or lapses in such insurance coverage for such period.

Section 7.11 Severability. In the event that any provision of this Agreement shall be determined for any reason to be invalid, illegal or unenforceable in any respect by any court of competent jurisdiction, the Parties shall negotiate in good faith and agree to such amendments, modifications or supplements of or to this Agreement or to such other appropriate actions as, to the maximum extent practicable in light of such determination, shall implement and give effect to the intentions of the Parties as reflected herein. Notwithstanding such determination, such determination shall not invalidate or render any other provision hereof unenforceable.

Section 7.12 Governing Law. The obligations of the Seller and the Purchaser under the terms of this Agreement shall be governed by and construed and interpreted in accordance with the laws of the State of New York.

Section 7.13 Liability of Officers and Employees. Except to the extent provided by Applicable Laws, no officer, official, commissioner, trustee, agent , representative, director, member, attorney or employee of any Party or affiliates of the Purchaser shall be charged personally by the other party or held contractually liable thereto under any term or provision of this Agreement, because of any Party's execution or attempted execution or because of any breach or alleged breach thereof; provided however, that all persons and Parties remain solely responsible for any of their own criminal or fraudulent actions.

Section 7.14 Third Party Beneficiaries. It is not intended that this Agreement make any Person or entity a third party beneficiary hereof, notwithstanding the fact that Persons or entities other than the Purchaser and the County may be benefited thereby.

Section 7.15 Merger Clause. This Agreement (including the Schedules hereto) constitutes the entire agreement and understanding of the Parties with respect to the conveyance of the Facility Assets and all other matters addressed or referred to herein and supersedes all prior and contemporaneous agreements and understandings, representations and warranties, whether oral or written, relating to such matter.

Section 7.16 Counterparts. This Agreement may be executed in any number of counterparts with the same effect as if the signature and seals thereto and hereto were upon the same instrument.

Section 7.17 Survival. All representations, warranties, covenants, stipulations, certificates, indemnities, and agreements contained herein or in any document delivered pursuant hereto shall survive the consummation of the transactions provided for in this Agreement.

[No further text on this page; Signature page follows]

IN WITNESS WHEREOF, the Corporation, Operator and the Purchaser have executed this Agreement, intending to be legally bound hereby as of the day and year first above written.

SELLER:
ORLEANS COUNTY HEALTH FACILITIES CORPORATION

By: _____
Name: Russell Martino
Title: Director, Chairman

By: _____
Name: Richard DeCarlo, Sr.
Title: Director, Vice-Chairman

By: _____
Name: Richard Moy
Title: Director, Treasurer/Secretary

OPERATOR:
COMPREHENSIVE AT ORLEANS LLC

By: _____
Name: Mordy Lahasky
Title: Authorized Member

REAL PROPERTY PURCHASER:
TELEGRAPH REALTY LLC

By: _____
Name:
Title: Authorized Member

IN WITNESS WHEREOF, the Corporation, Operator and the Purchaser have executed this Agreement, intending to be legally bound hereby as of the day and year first above written.

SELLER:
ORLEANS COUNTY HEALTH FACILITIES CORPORATION

By: Russell Martino
Name: Russell Martino
Title: Director, Chairman

By: Richard DeCarlo, Sr.
Name: Richard DeCarlo, Sr.
Title: Director, Vice-Chairman

By: Richard Moy
Name: Richard Moy
Title: Director, Treasurer/Secretary

OPERATOR:
COMPREHENSIVE AT ORLEANS LLC

By:
Name: Mordy Lahasky
Title: Authorized Member

REAL PROPERTY PURCHASER:
TELEGRAPH REALTY LLC

By:
Name:
Title: Authorized Member

[Acknowledgment Page to Purchase and Sale Agreement]

STATE OF NEW YORK)
COUNTY OF ORLEANS) ss.:

On the 6th day of February in the year 2014 before me, the undersigned, personally appeared **RUSSELL MARTINO**, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

FRANCIS L. GORMAN III
Notary Public, State of New York
Monroe County
My Commission Expires May 16, 2014

Notary Public

STATE OF NEW YORK)
COUNTY OF ORLEANS) ss.:

On the 6th day of February in the year 2014 before me, the undersigned, personally appeared **RICHARD DeCARLO, SR.**, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

FRANCIS L. GORMAN III
Notary Public, State of New York
Monroe County
My Commission Expires May 16, 2014

Notary Public

STATE OF NEW YORK)
COUNTY OF ORLEANS) ss.:

On the 6th day of February in the year 2014 before me, the undersigned, personally appeared **RICHARD MOY**, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

FRANCIS L. GORMAN III
Notary Public, State of New York
Monroe County
My Commission Expires May 16, 2014

Notary Public

STATE OF NEW YORK)
COUNTY OF Nassau) ss.:

On the 5th day of February in the year 2014 before me, the undersigned, personally appeared **MORDY LAHASKY**, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

JOSEPH W. GRAYSON
Notary Public, State of New York
No. 01GR6264224
Qualified in Queens County
Commission Expires 01/17/20 17

Notary Public

STATE OF NEW YORK)
COUNTY OF _____) ss.:

On the ___ day of February in the year 2014 before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

PERFORMANCE GUARANTY

For good and valuable consideration, the undersigned (collectively, the "**Guarantors**"), each hereby jointly, severally, irrevocably, absolutely and unconditionally guarantees to **ORLEANS COUNTY HEALTH FACILITIES CORPORATION** (the "**Corporation**") and its assigns the full and prompt payment of the Acquisition Price as required to be paid by **COMPREHENSIVE AT ORLEANS LLC** and **TELEGRAPH REALTY LLC** (collectively, the "**Purchaser**"). The within guarantees are independent of and in addition to any other guaranty, endorsement, collateral, remedy, statutory right or other agreement held by the Corporation or its assigns and are a guaranty of payment and performance, not of collection.

Dated: As of 2-5-14

Bernard Fuchs

Mordy Lahusky

Benjamin Landa

[Acknowledgment Page to Performance Guaranty]

State of New York)
County of Nassau) ss.:

On the 5th day of February in the year 2014, before me, the undersigned, personally appeared **BERNARD FUCHS**, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signatures on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

JOSEPH W. GRAYSON
Notary Public, State of New York
No. 01GR6254224
Qualified in Queens County
Commission Expires 01/17/20 17

Notary Public

State of New York)
County of Nassau) ss.:

On the 5th day of February in the year 2014, before me, the undersigned, personally appeared **MORDY LAHASKY**, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signatures on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

JOSEPH W. GRAYSON
Notary Public, State of New York
No. 01GR6254224
Qualified in Queens County
Commission Expires 01/17/20 17

Notary Public

State of New York)
County of Nassau) ss.:

On the 5th day of February in the year 2014, before me, the undersigned, personally appeared **BENJAMIN LANDA**, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signatures on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

JOSEPH W. GRAYSON
Notary Public, State of New York
No. 01GR6254224
Qualified in Queens County
Commission Expires 01/17/20 17

Notary Public

EXHIBIT A

FACILITY REAL PROPERTY

All that tract or parcel of land situate in part of Town Lot 10, Township 15, Range 2, Holland Land Company, Town of Albion, County of Orleans, State of New York, all as shown on a map entitled "Orleans County Health Facility Parcel A, B & C Exhibit", prepared by Costich Engineering, P.C., having Drawing. No. 5226 VS-100, dated 8/1/2013, and being more particularly bounded and described as follows:

Commencing at a point being the northeast corner of lands now or formerly owned by Orleans County Infirmary having T.A. # 72.00-02-22, said point also being a point on the south right-of-way line of New York State Route 31; thence

A. S88°24'25"W, and along said south bounds of New York State Route 31 a distance of 50.00 feet to the point and place of beginning.

1. S01°04'08"W, a distance of 591.22 feet to a point; thence
2. N88°55'52"W, a distance of 144.07 feet to a point; thence
3. S57°34'31"W, a distance of 234.18 feet to a point; thence
4. N77°51'41"W, a distance of 350.04 feet to a point; thence
5. N01°04'08"E, a distance of 438.85 feet to a point; thence
6. S88°55'52"E, a distance of 150.00 feet to a point; thence
7. N01°04'08"E, a distance of 151.47 feet to a point on said south bounds of New York State Route 31; thence
8. N77°59'58"E, and along said south bounds of New York State Route 31, a distance of 42.35 feet to a point; thence
9. N80°37'05"E, and along said south bounds of New York State Route 31, a distance of 128.52 feet to a point; thence
10. N83°14'10"E, and along said south bounds of New York State Route 31, a distance of 128.53 feet to a point; thence
11. N85°51'26"E, and along said south bounds of New York State Route 31, a distance of 32.64 feet to a point; thence
12. N88°24'25"E, and along said south bounds of New York State Route 31, a distance of 205.63 feet to the point and place of beginning. Containing 9.305 acres of land, more or less.

EXHIBIT A-1

FACILITY BUSINESS ASSETS

All items of personal property used or useful in the operations of the Facility to the extent historically used primarily to support the Facility and excluding those non-material items to be reasonably determined by the Corporation on notice to Purchaser 30 days prior to Closing including the rights to trade names or marks, including the rights to the name The Villages of Orleans Health & Rehabilitation Center. Upon request of Purchaser, Seller shall provide an itemized list.

EXHIBIT 5

AMENDED AND RESTATED

OPERATING AGREEMENT

OF

TELEGRAPH REALTY, LLC

A NEW YORK LIMITED LIABILITY COMPANY

Effective Date:

AMENDED AND RESTATED
OPERATING AGREEMENT
OF
TELEGRAPH REALTY, LLC

THIS AMEMDED AND RESTATED OPERATING AGREEMENT (the "Agreement") is entered into effective as of the _____ 2015 (the "Effective Date"), by and among the parties identified as Members on **Exhibit A** attached hereto, as Members.

RECITALS

A. The Company was formed as a New York limited liability company on January 29, 2014, by the filing of Articles of Organization with the Secretary of State of New York.

B. The Company, the Members desire to provide for certain agreements governing the business and affairs of the Company with and upon and conditions set forth in this Agreement.

ARTICLE I
FORMATION OF LIMITED LIABILITY COMPANY

1.1 By executing this Agreement or any counterpart thereof, each Member ratifies and approves the Articles of Organization as so filed and all amendments thereto filed on or before the date of the Member's execution of this Agreement.

1.2 The Company has been organized as a limited liability company and the Members intend that this Agreement shall serve as the Operating Agreement of the Company and all prior Operating Agreements are hereby declared null and void. The rights and liabilities of the Members shall be as provided by law, except as otherwise expressly provided in this Agreement.

1.3 The registered office of the Company shall be as designated by the Members from time to time with approval of a Supermajority.

1.4 The Members shall cause the Company to be qualified, formed or registered under assumed or fictitious name statutes or similar laws in any jurisdiction in which the Company conducts business and in which such qualification, formation or registration is required by law or deemed advisable by the Members. The Members, as an authorized person within the meaning of the Act, shall execute, deliver and file any certificates (and any amendments and/or restatements thereof) necessary for the Company to qualify to do business in a jurisdiction in which the Company may wish to do business. The Members shall be authorized to designate on behalf of the Company a registered agent and a registered office (or their respective equivalent) as may be required by applicable law in each jurisdiction in which the Company is qualified, formed or registered.

1.5 It is the intent of the Members that the Company shall always be treated and operated in a manner consistent with treatment as a "partnership" for federal and state income tax purposes. No Member shall take any action inconsistent with such intent.

ARTICLE II

NAME

The business of the Company shall hereafter be conducted under the name "TELEGRAPH REALTY, LLC ", or such other name(s) as the Members with approval of a Supermajority shall hereafter designate.

ARTICLE III

DEFINITIONS

The following terms used in this Operating Agreement shall have the following meanings (unless otherwise expressly provided herein):

"Act" means the Limited Liability Company Law of the Consolidated Laws of New York, Section 203, *et seq.*, as it may be amended from time to time, and any successor to said Statute.

"Adjusted Capital Contribution" means, as of any day, the aggregate Capital Contributions made by a Member (as well as by its Affiliates and prior Members from whom Units or Interests were acquired), reduced by all distributions of Distributable Cash to such Member which were intended or designated as the return of the Capital Contributions of such Member, including distributions pursuant to Sections 10.1(a)(ii) and 10.1(c)(iv) hereof.

"Affiliate" means, with respect to any Person: (a) any other Person directly or indirectly controlling, controlled by or under common control with the subject Person or (b) any officer, director, trustee, member or general partner of the subject Person, provided that, for the purposes of this definition, "control" (including, with correlative meanings, the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting securities, by contract or otherwise.

"Agreement" means this Amended and Restated Operating Agreement, as amended, modified, restated or supplemented from time to time.

"Articles" means the Articles of Organization of the Company, as filed with the New York Secretary of State, as the same may be amended from time to time.

"Book Value" means, with respect to any Company property, the Company's adjusted basis for federal income tax purposes, except that:

(a) the initial Book Value of any asset contributed by a Member to the Company shall be the gross fair market value of the asset, as determined by the contributing Member and the Company;

(b) the Book Value of all the Company's assets shall be adjusted to equal their respective gross fair market values, as determined by the Members, as of the following times: (i)

the acquisition of an additional Membership Interest in the Company in exchange for more than a *de minimis* Capital Contribution; (ii) the distribution by the Company of more than a *de minimis* amount of property as consideration for an interest in the Company; and (iii) the liquidation of the Company within the meaning of Treasury Regulations Section 1.704-1(b)(2)(ii)(g); provided, however, that the adjustments pursuant to clauses (i) and (ii) above shall be made only if the Members reasonably shall determine that the adjustments are necessary or appropriate to reflect the Members' relative economic interests in the Company;

(c) the Book Value of any Company asset distributed to a Member shall be the gross fair market value, taking Code Section 7701(g) into account, of the asset on the date of distribution; and

(d) the Book Value of Company assets shall be increased (or decreased) to reflect any adjustments to the adjusted basis of the assets pursuant to Code Section 734(b) or Code Section 743(b), but only to the extent that the adjustments are taken into account in determining Capital Accounts pursuant to Treasury Regulations Section 1.704-1(b)(2)(iv)(m).

If the Book Value of an asset has been determined or adjusted pursuant to paragraph (a), (b) or (d) immediately above, then the Book Value shall thereafter be adjusted by the Depreciation taken into account with respect to the asset for purposes of computing Net Profits and Net Losses.

"Capital Account" as of any given date shall mean the account established and maintained by the Company for each Member, as determined and adjusted up to the date in question pursuant to Article VIII hereof.

"Capital Contribution" shall mean any contribution to the capital of the Company in cash or property by a Member, whenever made.

"Initial Capital Contribution" shall mean the initial contributions to the capital of the Company by the Members pursuant to Section 8.1 of this Agreement.

"Class A Members" shall mean the Members designated as Class A Members on Exhibit A hereto and who have met the requirements to become a Member under this Agreement.

"Code" shall mean the Internal Revenue Code of 1986, as amended, or the corresponding provisions of subsequently enacted federal revenue laws.

"Company" means TELAGRAPH REALTY, LLC, which has been formed by the filing of the Articles pursuant to the Act and is governed by the Articles and this Agreement, as said entity may from time to time be constituted.

"Depreciation" means, for each fiscal year or other period, an amount equal to the depreciation, amortization, or other cost recovery deduction allowable with respect to an asset for the year or other period, except that if the Book Value of an asset differs from its adjusted basis for federal income tax purposes at the beginning of a year or other period, Depreciation shall be an amount which bears the same ratio to the beginning Book Value as the federal income tax depreciation, amortization, or other cost recovery deduction for the year or other period bears to the beginning adjusted tax basis; provided, however, that if the federal income tax depreciation,

amortization, or other cost recovery deduction for the year is zero, Depreciation shall be determined with reference to the beginning Book Value using any reasonable method selected by the Members with approval of a Supermajority.

"Distributable Cash" shall mean all cash, revenues and funds received by the Company from Company operations, less the sum of the following to the extent paid or set aside by the Company: (a) all payments of principal, interest and other sums due on loans or indebtedness incurred by the Company; (b) all cash expenditures incurred or accrued incident to the normal operation of the Company's activities; (c) all fees and expenses due to the Members and their Affiliates, including without limitation those set forth in Section 10.2 hereof, but excluding the fees described in Section 10.2(b) and 10.2(c) hereof; and (d) such Reserves as the Members deem reasonably necessary for the proper operation of the Company's business.

"Economic Interest" means a share of one or more of the Company's Net Profits, Net Losses, Distributable Cash, and the other assets of the Company, pursuant to this Agreement and the Act, but shall not include any right to participate in the management or affairs of the Company nor the right to vote on, consent to, or otherwise participate in any decision of the Members. Economic Interests may be evidenced by Units and shall be considered intangible personal property for purposes of applicable law and this Agreement.

"Fiscal Year" shall mean the Company's fiscal year, which shall be the calendar year as set forth in Article XII hereof.

"HUD" shall mean the United States Department of Housing and Urban Development.

"Majority Interest" shall mean the Member or Members (or such Members' designees) holding that number of Units of any Class when taken together, exceed fifty percent (50%) of the aggregate of all Units of any Class then outstanding and held by Members.

"Member" shall mean each Person who executes a counterpart of this Amended and Restated Operating Agreement as a Member and each Person who may hereafter become a Member of the Company.

"Members" shall refer to all Members, regardless of the Class of the Membership Interests, unless otherwise expressly provided herein.

"Membership Interest" shall mean a Member's entire interest in the Company, including the Member's share of the Net Profits, Net Losses, Distributable Cash and other assets of the Company, and such other rights and privileges that the Member may enjoy by being a Member, all of which shall be evidenced by Units. A Membership Interest and the Units evidencing the Interest may be designated as "Class A", "Class B" or another Class as provided elsewhere in this Agreement, and the Member who holds such Membership Interest and Units shall have the rights of such Class and shall be subject to the limitations of such Class, all as described in this Agreement. A Membership Interest shall constitute intangible personal property for all purposes under applicable law and this Agreement.

"Net Losses" shall mean, for each Fiscal Year, the losses and deductions of the Company determined in accordance with accounting principles consistently applied from year to year

employed under the accrual method of accounting and as reported, separately or in the aggregate, as appropriate, on the Company's information tax return filed for federal income tax purposes, plus any expenditures described in Section 705(a)(2) (B) of the Code.

"Net Profits" shall mean, for each Fiscal Year, the income and gains of the Company determined in accordance with accounting principles consistently applied from year to year employed under the accrual method of accounting and as reported, separately or in the aggregate, as appropriate, on the Company's information tax return filed for federal income tax purposes, plus any income described in Section 705(a)(1)(B) of the Code.

"Percentage Interest" shall mean, as of a particular date, the proportion that a person's aggregate Units of any class bears to the aggregate number of all issued and outstanding Units, as measured on the specified date. The Percentage Interests may be adjusted from time to time upon the issuance or redemption of Units or as otherwise required in this Agreement.

"Person" shall mean any individual, general or limited partnership, limited liability company, corporation, joint venture, trust, business trust, estate, cooperative or association or any foreign trust or foreign business organization, and their heirs, executors, administrators, legal representatives, successors and assigns where the context so permits.

"Preferred Return" means as to Class A Member, a cumulative return on such Class A Member's average daily Unrecovered Capital Contributions, non-compounded, at a rate per annum equal to the Prime Lending Rate plus 3% as published by the Wall Street Journal on January, 1 of the year in question.

"Property" shall mean any real, personal or intangible property now or hereafter acquired by the Company.

"Purchase Agreement" are any agreements entered into with the County of Erie.

"Reserves" shall mean, with respect to any fiscal period, funds set aside or amounts allocated during such period to reserves which shall be maintained in amounts deemed sufficient by the Members for working capital, to pay taxes, insurance, debt service or other costs or expenses incident to the operation of the Company's business, for liabilities of the Company not yet due, and/or future or contingent liabilities of the Company, including without limitation, such reserves as may be required by HUD or any lender.

"Supermajority" shall mean (i) the affirmative vote or consent of 75% of all Class A Members (or their respective designees) of the Company or their designee.

"Transfer" means, whether capitalized or not capitalized, the sale, assignment, gift, transfer, withdrawal, mortgage, pledge, hypothecation, exchange or other disposition of any part or all of a Member's Membership Interest, whether voluntarily, by operation of law, or otherwise.

"Treasury Regulations" shall include proposed, temporary and final regulations promulgated under the Code in effect as of the date of filing the Articles and the corresponding sections of any regulations subsequently issued that amend or supersede such regulations.

"Unanimous Member Approval" "Unanimous Approval" of "Unanimous Approval of the Members" shall mean the affirmative vote or consent of all Class A Members (or their respective designees) of the Company.

"Unrecovered Capital Contributions" shall mean, with respect to any Class A Member at any time, the aggregate Capital Contributions made by such Member in cash or property up to such time, plus the Preferred Return but less the aggregate distributions theretofore received by such Member pursuant to Section 10.1(a)(i).

"Unit" means the evidence of a Membership Interest or an Economic Interest in the Company, which shall be designated as belonging to a particular class of Units and which will have the rights and limitations described in this Agreement for all outstanding Units of the same class.

"Withdrawal" means, with respect to any Member, the death or bankruptcy of such Member or a complete disposition of such Member's entire Interest in the Company made during the lifetime (or other existence) of such Member.

ARTICLE IV

PURPOSES

The purpose of the Company shall be to acquire and hold membership interests in business entities that operate skilled nursing facilities, senior living facilities, or ancillary businesses related thereto, and to do anything and all things permitted by the Act and by law. The Company shall possess and may exercise all powers and privileges granted by law, or by the Agreement, including incidental powers thereto, to the extent that such powers and privileges are necessary, customary, convenient or incidental to the attainment of the Company's purposes.

ARTICLE V

MEMBERS AND UNITS

5.1 Members. The names and mailing addresses of the Members, the number and class of their Units, and their initial Percentage Interests shall be set forth respectively in the attached Exhibit A. Such Exhibit A shall be amended by the Members from time to time upon the admission of new Members, the issuance of additional Units, or the payment of Additional Capital Contributions. The Company may treat the Person in whose name any Unit shall be registered on the books and records of the Company as a Member and the sole holder of such Unit for all purposes whatsoever and, accordingly, shall not be bound to recognize any equitable or other claims to or interest in such Unit on the part of any other Person, whether or not the Company shall have actual or other notice thereof.

5.2 Units. Initially, the Company shall be authorized to issue one class of Membership Interests to its Members - "Class A Units".

(a) Class A Units. Class A Units will initially be held by the persons designated as Class A Members on Exhibit A, subject to such persons fulfilling the requirements to become

a Member hereunder including in the case of all Class A members, the timely funding of their initial capital contribution in its entirety. Class A Members will contribute capital to the Company as provided in this Agreement. No person other than those who are Class A Members at the time of formation can become Class A Members except to the extent that a Class A Member transfers the same to a spouse, or child or a trust for the benefit of the foregoing.

(b) Class B Units. Class B Units are reserved.

(c) Class C Units. Class C Units are reserved. The Class C Members will contribute capital as required of Class A Members, but shall have no Voting rights.

(d) Additional Classes of Units. The Members may authorize from time to time the issuance of additional classes of Units, with such rights and limitations as shall be approved by a Supermajority.

ARTICLE VI

TERM

The term of the Company commenced on the date that the Articles were filed in the office of the Secretary of State of New York (the "Formation Date") and shall continue perpetually, unless and until the Company is dissolved in accordance with the provisions of either this Agreement or applicable law.

ARTICLE VII

PRINCIPAL PLACE OF BUSINESS

The principal place of business of the Company shall be located at 14012 Route 31 West, Albion, NY in the County of Orleans, New York, or such other place as the Members may designate and is approved by a Supermajority. The books and records of the company shall be located at 14012 Route 31 West, Albion, NY in the County of Orleans, New York, or such other place as the Members may designate and is approved by a Supermajority.

ARTICLE VIII

CAPITAL CONTRIBUTIONS

8.1 Additional Capital Contributions. If a Supermajority determines that additional capital is necessary for the ongoing operation of the business of the Company, capital improvements or the like, then additional capital may be raised by the through additional Capital Contributions from the Class A Members. Additional Capital Contributions would be used to fund the obligations pursuant to the Purchase Agreement and the ongoing working capital of the Company or such other uses as the Members may determine upon a vote of a Supermajority. In exchange for such additional capital contribution (beyond the Initial Contribution) from the Members, the Member will receive no additional Units. Thereafter, if a Supermajority, each with

consent required herein, determines that additional capital beyond such Capital Contributions is required, then additional capital shall be raised through additional Capital Contributions from the Members. The Company may require from the Members additional Capital Contributions in such amounts and at such times as shall be stated in a written notice to the Members (the "Notice"), provided that all such requests shall be made to all Members in proportion to their Units at the time of the request. If a Member does not make timely payment of its full share of any additional Capital Contribution as requested in the Notice (a "Default Member"), then the other Members who have timely contributed their full share of the requested contribution (a "Contributing Member") shall have the right, but not the obligation, to (i) loan to the Company any funds (and funds that any Member may have forwarded pursuant to the Notice shall not be an additional capital contribution but will be part of the loan) specified in the Notice which were requested but not contributed by the Default Member (a "Rescue Loan") at a rate of interest equal at all times to 5% per annum over the "Base Rate" (or prime rate or similar equivalent rate) of interest from time to time in effect established by JPMorgan Chase Bank, and announced by it as the rate charged by it to its prime commercial customers on short-term unsecured borrowings (the "Prime Rate"), provided that such interest rate shall not exceed the maximum rate of interest permitted by applicable law or (ii) contribute the same as additional capital of the contributing member and dilute the shares of the noncontributing or underfunded Member(s). Dilution shall be an absolute right. Whenever more than one Contributing Member wishes to make a Rescue Loan for the same purpose, the Rescue Loans shall be made in equal amounts, or in such other proportions as the Contributing Members wishing to make the Rescue Loans shall agree, and such Rescue Loans shall be *pari passu* in priority. Each such Rescue Loan shall be due and payable as to all outstanding principal and accrued and unpaid interest on the first anniversary of the date on which the loan is advanced; provided however, that interest on Rescue Loans shall be due and payable quarterly, prior to any distributions to any Members, on a first-in, first-out basis, but taking into account Rescue Loans which are or are deemed *pari passu* in priority. All Distributable Cash shall be applied to the repayment of principal of Rescue Loans on a first-in, first-out basis, but taking into account Rescue Loans which are or are deemed *pari passu* in priority. Rescue Loans which are not *pari passu* in priority shall have priority against each other as to payment of interest and then of principal on a first-in, first-out basis. All of the aforesaid Rescue Loans will be obligations of the Company and of the other Members personally up to the amount that they were required to contribute. Should any Rescue Loan not be repaid within a period of One Year from the date of issue, the Member(s) providing such Rescue Loan(s) shall have the option of converting the same to equity by diluting the shares of the non-contributing Members, upon 30 days written notice to Company and the non-contributing or underfunded Member(s). Member shall have no right to prevent such conversion, even if they attempt to make a contribution to cover repayment of the Rescue Loan after notice is tendered.

8.2 Loans to Company. With the prior approval of a Supermajority, a Member may lend to the Company such funds as reasonably required for the continuation of its business operations and activities. Such loans shall be made on such terms and conditions that are approved by a Supermajority and shall, unless decided by Unanimous vote, be on terms that are economically similar to what is available in the commercial or private markets after reasonable inquiry of institutional lenders, investment bankers and or private lenders for loans with equivalent size, credit and collateral.

8.3 Capital Accounts.

(a) A separate Capital Account will be maintained for each Member. Each Member's Capital Account will be increased by (1) the amount of money contributed by such Member to the Company; (2) the agreed fair market value of Property contributed by such Member to the Company (net of liabilities secured by such contributed Property that the Company is considered to assume or take subject to under Section 752 of the Code); and (3) the amount of Net Profits allocated to such Member. Each Member's Capital Account will be decreased by (1) the amount of money distributed to such Member by the Company; (2) the agreed fair market value of Property distributed to such Member by the Company (net of liabilities secured by such distributed Property that such Member is considered to assume or take subject to under Section 752 of the Code); and (3) the amount of Net Losses allocated to such Member.

(b) For purposes of computing the amount of any item of Company income, gain, loss or deduction to be reflected in the Members' Capital Accounts and to be allocated pursuant to this Agreement, the determination, recognition and classification of any such item shall be the same as its determination, recognition and classification for federal income tax purposes (including any method of depreciation, cost recovery or amortization used for this purpose), provided that:

(i) The computation of all items of income, gain, loss and deduction shall include income and expense of the Company that is exempt from federal income tax and also those items described in Code Section 705(a)(1)(B) or Treasury Regulations Section 1.704-1(b)(2)(iv)(i), without regard to the fact that such items are not includible in gross income or deductible for federal income tax purposes;

(ii) If the Book Value of any Company Property is adjusted pursuant to paragraphs (b) or (c) of the definition of "Book Value" set forth in this Agreement, the amount of such adjustment shall be taken into account as gain or loss from a disposition of such Property;

(iii) Items of income, gain, loss or deduction attributable to the disposition of Company Property having a Book Value that differs from its adjusted basis for federal income tax purposes shall be computed by reference to the Book Value of such Property; and

(iv) Items of Depreciation with respect to Company Property having a Book Value that differs from its adjusted basis for federal income tax purposes shall be computed by reference to the Book Value of such property in accordance with Treasury Regulations Section 1.704-1(b)(2)(iv)(g).

(c) In the event of a permitted Transfer of Membership Interests pursuant to Article XVII hereof, the Capital Account of the Transferring Member shall become the Capital Account of the transferee to the extent it relates to the transferred Membership Interest in accordance with Section 1.704-1(b)(2)(iv) of the Treasury Regulations.

(d) The manner in which Capital Accounts are to be maintained pursuant to this Agreement is intended to comply with the requirements of Code Section 704(b) and the Treasury Regulations promulgated thereunder. If, in the opinion of the Members, with the advice of the

Company's counsel, the manner in which Capital Accounts are to be maintained pursuant to the preceding provisions of this Section 8.4 should be modified in order to comply with Section 704(b) of the Code and the Treasury Regulations, then notwithstanding anything to the contrary contained in the preceding provisions of this Section 8.4, the method in which Capital Accounts are maintained shall be so modified.

(e) Except as otherwise required by law, no Member shall have any liability or obligation, whether to the Company, to another Member or to any other person, to restore all or any portion of a deficit balance in such Member's Capital Account to the extent such Member is otherwise in compliance with the terms of this Agreement.

8.4 Interest on and Return of Members' Capital Contributions. No Member has the right to demand and receive interest on his, her or its Capital Contributions or a return of his, her or its Capital Contribution, except as otherwise specifically provided in this Agreement.

8.5 Liability of Members. Except as required under the Act or any other provision of this Agreement, no Member shall have any personal liability for debts or other obligations of the Company, including, without limitation, obligations for local, state and federal taxes.

ARTICLE IX

ALLOCATIONS OF NET PROFITS AND LOSSES

9.1 Allocations.

(a) After giving effect to the special allocations set forth in Section 9.2, the Company's Net Profits, if any, and the Company's Net Losses, if any, for each Fiscal Year or other accounting period shall be allocated among the Members in a manner that will, as nearly as possible, cause the capital account balance of each such Member at the end of such accounting period to equal the hypothetical distribution, if any, that such Member would receive if, on the last day of such period: (x) all of the Company's assets, including cash, were sold for cash equal to their book values (as determined for purposes of maintaining capital accounts in accordance with Section 8.4 hereof), taking into account any adjustments thereto for such period; (y) all Company liabilities reflected on the face of the Company's balance sheet were satisfied in cash according to their terms (limited, with respect to each nonrecourse liability, to the book value (as so determined) of the Company assets securing such liability) and (z) the net remaining proceeds thereof were distributed in full to the Members in the order of priority described in Section 10.1(c).

(b) The Members intend that the allocations of Net Profits and Net Losses under this Agreement will produce final capital account balances of each Member equal to the aggregate amount of liquidating distributions to which such Member will be entitled under Section 10.1(c) hereof. If such allocation provisions would fail to produce such final capital account balances, (i) such allocation provisions may be amended by the Members if and to the extent necessary to produce such result, and (ii) Net Profits and Net Losses (or items of gross income, gain, loss and deduction, if necessary) for prior Fiscal Years for which amended tax returns may still be filed may be reallocated among the Members to the extent it is not possible to achieve such result with allocations of such items for the current and future Fiscal Years.

(c) Other Items. Any other item of income, gain, loss, expense or credit in any Fiscal Year which is not covered by the preceding provisions of this Section 9.1 or elsewhere in this Article IX shall be allocated among the Members in accordance with their Percentage Interests as they exist from time to time during such Fiscal Year.

(d) New Members. If any new Member is admitted to the Company, a Supermajority shall determine the appropriate adjustments to make to this Section 9.1 as well as Section 9.2, and in accordance with Section 706 of the Code, whether to prorate items of income and deduction according to the portion of the year for which such person was a Member of the Company or whether to close the books of the Company on an interim basis and divide the Fiscal Year into two or more segments.

(e) Economic Interests. The allocations and other provisions of this Article IX shall apply to any holder of any Economic Interest in the Company, effective upon the date of acquisition of such Economic Interest and without regard to whether such holder is admitted as a Member.

9.2 Special Allocations. The following special allocations shall be made in the following order:

(a) Minimum Gain Chargeback. Notwithstanding any other provision of this Article, if there is a net decrease in Company minimum gain during any Fiscal Year, each Member shall be specially allocated items of Company income and gain for such year (and, if necessary, subsequent years) in an amount equal to that Member's share of the net decrease in Company minimum gain (within the meaning of Treasury Regulations Section 1.704-2(g)(2)). Allocations pursuant to the previous sentence shall be made in proportion to the respective amounts required to be allocated to each Member pursuant thereto. This Section is intended to comply with the minimum gain chargeback requirement in Treasury Regulations Section 1.704-2(f) and shall be interpreted consistently therewith.

(b) Member Minimum Gain Chargeback. Notwithstanding any other provision of this Article, except as provided in Section 9.2(a), if there is a net decrease in Member minimum gain attributable to a Member nonrecourse debt during any Fiscal Year, each Member who has a share of the Member minimum gain attributable to such Member nonrecourse debt, determined in accordance with Treasury Regulations Section 1.704-2(i)(5) shall be specially allocated items of Company income and gain for such year (and if necessary, subsequent years) in an amount equal to the Person's share of the net decrease in Member minimum gain attributable to such Member nonrecourse debt, determined in accordance with Treasury Regulations Section 1.704-2(i)(4). Allocations pursuant to the previous sentence shall be made in proportion to the respective amounts required to be allocated to each Member pursuant thereto. This Section is intended to comply with the minimum gain chargeback requirement in Treasury Regulations Section 1.704-2(i)(4) and shall be interpreted consistently therewith.

(c) Qualified Income Offset. Notwithstanding anything in this Article, if a Member unexpectedly receives an adjustment, allocation or distribution described in Treasury Regulations Section 1.704-1(b)(2)(ii)(d)(4), (5) or (6), and such unexpected adjustment, allocation or distribution puts such Member's Capital Account into a deficit balance or increases such deficit

balance, such Member shall be allocated items of income or gain of the Company in an amount and manner sufficient to eliminate such deficit as quickly as possible, provided that an allocation pursuant to this Section 9.2(c) shall be made if and only to the extent that such Member would have a deficit balance in the Member's Capital Account after all other allocations provided for in Section 9.2 have been tentatively made as if this Section 9.2(c) were not in the Agreement. It is intended that this Section 9.2(c) shall meet the requirement that this Agreement contain a "qualified income offset" as defined in Treasury Regulations Section 1.704-1(b)(2)(ii)(d) and this Section shall be interpreted and applied consistently therewith.

(d) Gross Income Allocation. In the event any Member has a deficit Capital Account at the end of any Fiscal Year which is in excess of the sum of (i) the amount such Member is obligated to restore pursuant to any provision of this Agreement, and (ii) the amount such Member is deemed to be obligated to restore pursuant to the penultimate sentences of Treasury Regulations Sections 1.704-2(g)(1) and 1.704-2(i)(5), each such Member shall be specially allocated items of gross income of the Company in the amount of such excess as quickly as possible, provided that an allocation pursuant to this Section 9.2(d) shall be made only if and to the extent that such Member would have a deficit Capital Account in excess of such sum after all other allocations provided for in this Article have been made as if Section 9.2(c) and this Section 9.2(d) were not in the Agreement.

(e) Nonrecourse Deductions. Nonrecourse deductions for any Fiscal Year or other period shall be specially allocated to the Members in accordance with their respective Percentage Interests.

(f) Member Nonrecourse Deductions. Any Member nonrecourse deductions for any Fiscal Year or other period shall be specially allocated to the Member who bears the economic risk of loss with respect to the Member nonrecourse debt to which such Member nonrecourse deductions are attributable, in accordance with Treasury Regulations Section 1.704-2(i).

(g) Section 754 Adjustments. To the extent an adjustment to the adjusted tax basis of any Company asset pursuant to Code Sections 732, 734(b) or 743(b) is required, pursuant to Treasury Regulations Section 1.704-1(b)(2)(iv)(m), to be taken into account in determining Capital Accounts, the amount of such adjustment to the Capital Accounts shall be treated as an item of gain (if the adjustment increases the basis of the asset) or loss (if the adjustment decreases such basis) and such gain or loss shall be specially allocated to the Members in a manner consistent with the manner in which their Capital Accounts are required to be adjusted pursuant to such Section of the Treasury Regulations.

(h) Curative Allocations. The allocations set forth in this Section 9.2 (the "Regulatory Allocations") are intended to comply with certain requirements of Treasury Regulations Section 1.704-1(b). Notwithstanding any other provision of this Article (other than the Regulatory Allocations), the Regulatory Allocations shall be taken into account in allocating other items of income, gain, loss, and deduction, and credit among the Members so that, to the extent possible, the net amount of such allocations of other items and the Regulatory Allocations to each Member shall be equal to the net amount that would have been allocated to each such Member if the Regulatory Allocations had not occurred.

(i) Tax Allocations: Section 704(c) of the Code. In accordance with Section 704(c) of the Code, income, gain, loss and deduction with respect to any property contributed by any Member to the Company shall, solely for tax purposes, be allocated among the Members so as to take account of any variation between the adjusted basis of such property to the Company for federal income tax purposes and its Book Value, in the same manner as such variations are treated under Section 704(c) of the Code. Any elections or other decisions related to such allocations shall be made by the Members in any manner that reasonably reflects the purpose and intention of the Agreement. Allocations pursuant to this Section 9.2(i) are solely for purposes of federal, state and local taxes and shall not affect, or in any way be taken into account in computing any Member's Capital Account or share of income, gain, loss or deduction pursuant to any other provision of this Agreement.

9.3 Other Allocation Rules.

(a) Net Profits, Net Losses, and all other items of Company income, gain, loss, deduction and credit shall be determined by the Member on a daily, monthly or other basis, using any method permitted under Code Section 706 and the Treasury Regulations.

(b) The Members are aware of the tax consequences of the allocations required under this Article IX and each Member hereby agrees to be bound by the provisions of this Article IX in reporting such Member's share of Company income, gain, loss and deduction for federal income tax purposes.

(c) Solely for purposes of determining a Member's proportionate share of the "excess nonrecourse liabilities" of the Company (within the meaning of Treasury Regulations Section 1.752-3(a)(3)), the Members' interests in Company profits are in proportion to their Percentage Interests.

(d) If the Book Value of any Company Property is adjusted pursuant to Section 8.4(b), subsequent allocations of items of taxable income, gain, loss and deduction with respect to such Company Property shall take account of any variation between the tax basis of such Company Property and its Book Value in the same manner as required under Code Section 704(c).

9.4 Safe Harbor Election. On behalf of the Company, a Supermajority of the Members are authorized to elect the "safe harbor" described in the final Treasury Regulations and any other final pronouncements of the Internal Revenue Service that shall apply to any compensatory issuance of Units or other interests in this Company in consideration for the performance of services. Upon the making of such election by the Company, the Company and all Members shall comply with the requirements of such safe harbor while the election remains in effect.

ARTICLE X

DISTRIBUTIONS AND OTHER PAYMENTS

10.1 (a) Distributable Cash. Except as otherwise provided in Section 10.1(b) and Section 10.1(c) below, the Company shall distribute its Distributable Cash to the Members quarterly, as follows:

(i) First, to the holders of Class A Units until the holders of Class A Units have received an amount equal to their Unrecovered Capital Contributions; and

(ii) Second, to the Members or holders of Units in proportion to their respective Percentage Interests as they exist on the distribution date.

(b) Tax Distributions. Notwithstanding the distribution provisions of Section 10.1(a) hereof but subject to any HUD rules or regulations, the Company shall distribute out of the Distributable Cash to each of the Members, within One hundred and Twenty (120) days after the end of each Fiscal Year, an amount equal to forty percent (40%) (or such lesser percentage as determined by the Member to be necessary to cover the Members' aggregate tax obligations) of the aggregate Net Profits, if any, allocated to such Member for the most recently ended fiscal year of the Company, but only to the extent that such amount had not already been distributed to the Member under Section 10.1(a) during such Fiscal Year. To the extent paid, such "tax distributions" by the Company shall be applied to the Company's outstanding distribution obligations to the Members under Section 10.1(a).

(c) Liquidating Distributions. Upon liquidation (within the meaning of such term as set forth in Section 1.704-1(b)(2)(ii)(g) of the Treasury Regulations) of the Company or its Membership Interests, or within 30 days of receipt of the proceeds from the sale of substantially all of the assets of the Company, liquidating distributions will be made in the following manner:

(i) First, to the payment and discharge of all of the Company's debts and liabilities to creditors, including without limitation, all fees and expenses due under Section 10.2 hereof;

(ii) Second, to the payment and discharge of all of the Company's debts and liabilities to the Members including, without limitation, the Company's obligation to pay to the Members all outstanding fees and expenses;

(iii) Third, in accordance with Section 10.1(a)(i);

(iv) Fourth, in accordance with Section 10.1(a)(ii); and

(v) Thereafter, the balance, if any, to the Members, in accordance with their positive Capital Account balances, after giving effect to all contributions, distributions, and allocations required or provided in this Agreement for all prior periods;

10.2 Fees and Expenses. Without further approval from the Members, the Company shall be authorized to pay the operating expenses of the Company and to reimburse the Members for reasonable out of pocket expenses incurred by the Members, as applicable, for the benefit of the Company, including without limitation formation costs and costs of negotiating the Purchase Agreement and certain other operating agreements and purchase agreements, as may be approved by the Members. The Members shall have the further authority to pay to Members or their Affiliates additional fees for services rendered to the Company on such terms and at such times as shall receive Unanimous Member Approval.

10.3 Amounts Withheld. All amounts withheld as required by the Code or any provision of state or local law with respect to any payment or distribution to the Members shall be treated as amounts distributed to the Members pursuant to this Article X for all purposes under this Agreement. The Company may allocate any such amounts among the Members in any manner that is in accordance with applicable law.

10.4 No Third-Party Beneficiaries. The foregoing priorities of application of Distributable Cash are for the benefit of the Members only and not for the benefit of any third party or creditor of the Company or any Member, and none of the Company, nor other Members shall be liable or responsible to any third party or creditor of the Company or of the Members for any deviation from such priorities.

ARTICLE XI

BOOKS AND RECORDS

At the Company's expense, the Members shall maintain at the corporate headquarters of the Company or such other place as a Supermajority may designate proper and complete records and books of account in which shall be entered fully and accurately all transactions and other matters relating to the Company's business as are usually entered into records and books of account maintained by persons engaged in businesses of a like character shall be maintained at such Headquarters. The Company books and records shall be kept on the accrual basis, unless a different accounting method is permitted under applicable law and the approval of a Supermajority elects to employ such method. The books and records shall be open to the reasonable inspection and examination by the Members or their duly authorized representatives during reasonable business hours and each Member shall be permitted at his expense to audit the same. The Company shall cooperate in any such audit.

ARTICLE XII

FISCAL YEAR

The fiscal year of the Company shall end on _____ of each year.

ARTICLE XIII

COMPANY FUNDS

The funds of the Company shall be deposited in such bank account or accounts, or invested in such interest-bearing or non-interest-bearing investments. Company funds shall be separately identifiable from and not commingled with those of any other Person.

ARTICLE XIV

RIGHT AND DUTIES OF MEMBERS

14.1 Role in Management. The Members shall participate in the management and control of the Company's business, transact any business for the Company and have the power to act for or bind the Company upon affirmative vote of a Supermajority and as expressly set forth in the Articles or in this Agreement. Notwithstanding the foregoing, the Members shall obtain bids for any contract which is not terminable upon 90 days written notice or which has the aggregate value of more than $60,000 per annum. The Members shall always accept the lowest competent bidder. Should such vendor not be the least expensive, the Members shall so advise the Members and obtain approval of a Supermajority prior to utilizing the same. In no event shall any Member receive any kickback or undisclosed benefit from any Vendor or engage in any unlawful act.

Neither the management structure nor the provisions setting forth such structure may be deleted, modified or amended without the prior approval of the New York State Department of Health.

14.2 Liability for Company Debt. Unless a Member otherwise agrees in writing, no Member will be personally liable for any debts or losses of the Company, except as otherwise required by law. Notwithstanding the foregoing, each Class A Member agrees to guarantee any note and mortgage of the Company up to his percentage of interest.

14.3 The Initial Chief Executive Officers with all powers customarily conferred on an employee with that title is Sam Halper. For the first year, such Chief Executive Officer shall not be replaced without aSupermajorityVote of the Members unless (i) the Chief Executive Officer resigns or (ii) the Chief Executive Officer engaged in theft, dishonesty, fraudulent, or unlawful conduct, or gross dereliction of duty which has caused substantial injury. In the event the CEO resigns or engages in dereliction of duty in the first year, the other Members shall have the option to purchase his shares at his acquisition price. The CEO's salary shall be $100,0000 per year. The CEO position is not anticipated to be full-time, but he is obligated to have an active leadership role or he may be replaced by vote of a Majority of the Members.

14.4 Priority and Return of Capital. Except as may be expressly provided in this Agreement, no Member shall have priority over any other Member, either as to the return of Capital Contributions or as to Net Profits, Net Losses or distributions; provided that this Section shall not apply to Rescue Loans or other loans (as distinguished from Capital Contributions) which a Member has made to the Company nor to the fees described or otherwise approved as set forth in Section 10.2 hereof.

14.5 Liability of a Member to the Company. A Member holds as trustee for the Company money or other property wrongfully or erroneously paid or conveyed to such Member.

14.6 No Preemptive Rights. Except as otherwise provided in Section 20.1 hereof, no Member shall have any preemptive or preferential right, including any such right with respect to (a) issuance or sale of Membership Interests, whether unissued or hereafter created; (b) issuance of any obligations, evidences of indebtedness or other securities of the Company convertible into or exchangeable for, or carrying or accompanied by any rights to receive, purchase or subscribe to, any such unissued Units or other Membership Interest; (c) any warrant or option for the

purchase of, any of the foregoing securities; or (d) issuance or sale of any other securities that may be issued or sold by the Company.

14.7 Resignation/Withdrawal. A Member may voluntarily withdraw or resign from the Company only with the prior written consent of the Supermajority Interest of the other non-withdrawing Members, if any. A Member must resign if he is excluded or otherwise prohibited by any governmental agency from owning and/or operating Nursing home assets as the case may be. Such Member shall be entitled to receive from the Company for his, her or its Membership Interest an amount equal to the positive balance of the Member's Capital Account as of the effective date of the withdrawal or resignation within nine (9) months following the effective date of the withdrawal or resignation. A resigning or withdrawing Member shall be immediately required to pay any sums owed to the Company by such resigning Member (including, without limitation, any unpaid additional Capital Contributions duly requested as provided herein). The resignation or withdrawal of any Member from the Company without the prior written consent of a Supermajority Interest of the other Members shall constitute a wrongful dissociation. Any Member who wrongfully dissociates from the Company shall not be entitled to receive any payment for his, her or its Membership Interest from the Company prior to the dissolution and termination of the Company and shall be liable to the Company and/or other Members for any damages or expenses directly or indirectly caused by such resignation or withdrawal, which liability is in addition to any other obligation of that Member to the Company or to the other Members.

14.8 Independent Activities. Any of the Members may engage in or possess an interest in other business ventures of every nature and description, independently or with others, including, but not limited to, the ownership, leasing, or operations of skilled nursing facilities or senior living facilities, and neither the Company nor any of the other Members shall have any right by virtue of this Agreement in and to such independent ventures or to the income, profits or proceeds derived therefrom. Notwithstanding the foregoing, no Member may hire or cause or encourage others to hire persons employed by the Company or who have been employed by the Company anytime within 12 months of the hire date and no Member shall compete with the Facility or assist any other in competing with the Company in its market as defined by drawing residents from the same or overlapping feeder sources without Unanimous Approval of the Members.

14.9 Transactions with Affiliates. Agreement or transaction between the Company and any Member, or his, her or its Affiliates shall be void or voidable solely by reason of such relationship unless such relationship is disclosed and the Agreement or transaction is approved by a Supermajority. The execution of any such agreement or the entering into a consummation of such transaction by the Company shall not subject the participating Member, or any of his, hers or its Affiliates or their officers, directors, managing members, members or stockholders to liability to the Company or any Member for breach of fiduciary duty if (i) such agreement or transaction is on terms, taken as a whole, that are better than those available in the marketplace or (ii) a Supermajority approves or ratify such agreement or transaction.

ARTICLE XV

MEETINGS OF MEMBERS

15.1 Meetings. Meetings of the Members, for any purpose or purposes, unless otherwise prescribed by the Act, may be called by Member.

15.2 Place of Meetings. The Member may designate any place, within or without the State of New York as the place of meeting for any meeting of the Members. If no designation is made, or if a special meeting be otherwise called, the place of meeting shall be at the principal place of business of the Company. Telephonic participation shall be permitted.

15.3 Quorum. The Members holding a Majority Interest, represented in person or by proxy, shall constitute a quorum at any meeting of Members, but only those representing a Supermajority may take such action requiring a vote of a Supermajority and those representing a Unanimous Interest may take such action requiring a vote of a Unanimous Interest. In the absence of a quorum at any such meeting, a majority of the Units so represented may adjourn the meeting from time to time for a period not to exceed sixty (60) days without notice. However, if the adjournment is for more than sixty (60) days, or if after the adjournment a new record date is fixed for the adjourned meeting, a notice of the adjourned meeting shall be given to each Member of record entitled to vote at the meeting. At such adjourned meeting at which a quorum shall be present or represented, any business may be transacted which might have been transacted at the meeting as originally noticed. The Members present at a duly organized meeting may continue to transact business until adjournment, notwithstanding the withdrawal during such meeting of Members holding that number of Units whose absence would cause less than a quorum to be represented.

15.4 Manner of Acting. If a quorum is present, the affirmative vote of Members holding a Majority Interest shall be the act of the Members, unless the vote of a greater or lesser proportion or number is otherwise required by the Act, by the Articles, or by this Agreement.

15.5 Action by Members Without a Meeting. Action required or permitted to be taken at a meeting of Members may be taken without a meeting if the action is evidenced by one or more written consents describing the action taken, provided such consent is delivered to each Member entitled to vote and that signed consents from voting Members holding at least a Majority Interest are delivered to the Company for inclusion in the minutes or for filing with the Company records. Action taken under this Section is effective when the Members holding at least a Majority Interest have signed the consent, unless the consent specifies a different effective date. The record date for determining Members entitled to take action without a meeting shall be the date the first Member signs a written consent.

ARTICLE XVI

POWERS, RIGHTS AND DUTIES OF THE MEMBER

16.1 Authority of Member. Subject to the limitations herein, the Members shall be charged with responsibility for all day to day functions of the business of the Company. Without limiting the generality of the foregoing, the Members shall establish such business strategies, accounting procedures and other practices and to make such business decisions as the Members, subject to the Terms and Conditions of this Operating Agreement, deem advisable for the operation

of the Company. The foregoing said, Members shall not take any action without approval of a Supermajority which for similar goods, and/or services or the like, increases the cost to the Facility by more than 10% to the extent that the annual amount paid for all goods and services and all other amounts from that vendor is anticipated to be less than $50,000 per year and shall not take any action which increases the cost to the Facility by more than 5% for any vendor of the Company to the extent that the annual amount paid for all goods and services and all other amounts paid is anticipated to be $50,000 or more per year. Likewise Members shall not refuse to take action which saves the Company 5% for for any vendor to extent annual cost is anticipated to be $50,000 or more or refuse to take action which saves the Company 10% for any vendor where annual billings are anticipated to be less than $50,000. No vendor which is more expensive than the predecessor and other current bids shall receive a contract for services in excess of one year in length.

16.2 Certain Member Rights. The Members must obtain the consent of a Supermajority Interest before he, she or it may take any of the following actions:

(a) purchase corporate equity or debt securities, partnership interests, membership or economic interests in limited liability companies, or other investments, with a value of more than $50,000 in the aggregate;

(b) acquire real property, with a purchase price of more than $50,000 in the aggregate,

(c) acquire personal property, with a purchase price of more than $100,000 in the aggregate per facility owned directly or indirectly by the Company;

(d) borrow money for and in the name of the Company from banks, other lending institutions, the Members, or Affiliates of the Members, or guarantee indebtedness of an Affiliate, in an amount of more than $50,000 in the aggregate;

(e) invest any Company funds temporarily (by way of example but not limitation) in time deposits, short-term governmental obligations, commercial paper or other investments, in an amount of more than $100,000 in the aggregate;

(f) sell or otherwise dispose of all or substantially all of the Company's Property or any material portion thereof;

(g) sell or refinance any of the properties held by the Company or its direct or indirect subsidiary entities, provided, however, that no Member shall unreasonably withhold his, her or its consent hereunder provided that the net proceeds of such sale or refinance are used to pay the Class A Member all of its Unrecovered Capital Contributions;

(h) make capital or other expenditures in an amount greater than $50,000 in the aggregate (only to the extent in excess of amounts eligible for reimbursement by HUD);

(i) enter into any agreement for any of the foregoing;

(j) approve or permit the Company's direct or indirect subsidiary entities to take any of the foregoing actions.

Unless authorized to do so by this Agreement or by a Supermajority, no attorney-in-fact, employee, or agent of the Company shall have any power or authority to bind the Company in any way, to pledge its credit, or to render it liable pecuniarily for any purpose. No Member shall have any power or authority to bind the Company unless the Member has been authorized by a Supermajority to act as an agent of the Company in accordance with the previous sentence.

16.3 Indemnity of the Members. The Members shall be indemnified by the Company under the following circumstances and in the manner and to the extent indicated:

(a) In any threatened, pending or completed action, suit or proceeding to which a Member was or is a party or is threatened to be made a party by reason of the fact that he, she or it is or was a Member of the Company (other than an action by or in the right of the Company) involving an alleged cause of action for damages arising from the performance of his, her or its activities on behalf of the Company, the Company shall indemnify such Member against expenses, including reasonable attorney's fees, judgments and amounts paid in settlement, actually and reasonably incurred by him in connection with such action, suit or proceeding if the Member acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the Company (which determination shall be made as provided in the Act) and provided that his, her or its conduct has not been found by a nonappealable court judgment, order, decree or decision to constitute gross negligence, willful or wanton misconduct, or a breach of his, her or its fiduciary obligations to the Members. The termination of any action, suit or proceeding by judgment, order, settlement, or plea of nolo contendere shall not, of itself, create a presumption that the Member did not act in good faith and in a manner which he reasonably believed to be in or not opposed to the best interests of the Company.

(b) To the extent the Member has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in paragraph (a) above, or in defense of any claim, issue or matter therein, the Company shall indemnify the Member against the expenses, including attorney's fees, actually and reasonably incurred by him in connection therewith.

(c) The indemnification set forth in this paragraph shall in no event cause the Members to incur any liability beyond their total Capital Contributions plus their share of any undistributed Net Profits of the Company, nor shall it result in any liability of the Members to any third party. Likewise, under no circumstances shall any Member be indemnified for any unlawful act or civil penalty paid as a result of the commission of an act which if proven beyond a reasonable doubt would have criminal penalties.

ARTICLE XVII

TRANSFER OF MEMBERSHIP INTEREST

17.1 Transfer of Membership Interest. A Member shall not Transfer all or any part of his, her or its Units or Membership Interest without: (a) the prior consent of a Supermajority, and (b) full compliance with all provisions of Article XVII of this Agreement.

17.2 Restrictions on Transfer of Interests.

(a) Voluntary Transfer. If a Member desires to Transfer (in such capacity, a "Transferor") all or any portion of the Units it owns (the "Transferred Interests"), and has received a bona fide written offer (the "Offer") to Transfer the Transferred Interests to a third party which is not an Affiliate of such Transferor (the "Transferee"), the Transferor shall deliver a written notice (a "Transfer Notice") to the other Members of the Company (in such capacity, the "Non-Selling Members") of its desire to Transfer the Transferred Interests. The Transfer Notice shall state the number of Units the Transferor desires to Transfer, as well as the purchase price for the Transferred Interests (disclosed on both an aggregate and per Unit basis) and any terms and conditions of payment, all of which shall correspond to the price, terms and conditions set forth in the Offer. The Transfer Notice also shall include a true and complete copy of the Offer. For sixty (60) days following the other Member's receipt of the Transfer Notice (the "Company Option Period"), the Company shall have the exclusive option to purchase one or more of the Transferred Interests for the price per Unit and upon the terms and conditions of payment set forth in the Transfer Notice. If the Company does not exercise its option to purchase all, of such Transferred Interests during the Company Option Period, then for a period of sixty (60) days after the expiration of the Company Option Period (the "Non-Selling Members Option Period"), each Non-Selling Member shall collectively have the option to purchase up to its pro rata share of all of the Transferred Interests that the Company did not elect to purchase at the price per Unit and upon the terms and conditions set forth in the Transfer Notice. If the Company and the Non-Selling Members do not collectively exercise their option to purchase all, but not less than all, of such Transferred Interests by the end of the Non-Selling Members Option Period, then, at any time within one hundred fifty (150) days of the expiration of the Non-Selling Members Option Period, the Transferor may Transfer the Transferred Interests to the Transferee but only at a price that is at least equal to the price, and upon the other terms and conditions, set forth in the Transfer Notice and the Offer.

(b) Involuntary Transfers. In the event of the death, incompetency, bankruptcy; dissolution of a Member or in the event that such person is ineligible by governmental decree or action to own the assets of the Company (in such capacity, a "Withdrawing Member"), (i) for a period of ninety (90) days after the Company receives actual notice thereof, the Company shall have the option to purchase all, or any portion, of the Units and Membership Interests of the Withdrawing Member (the "Withdrawing Member's Interests"), for the price and upon the terms set forth in Section 17.2(e) below. If the Company does not exercise its option to purchase all of the Withdrawing Member's Interest, for a period ending thirty (30) days after the close of the Company's ninety (90) day option period, the non-Withdrawing Members (the "Non-Withdrawing Members") shall have an option to purchase all, but not less than all, of such Withdrawing Member's Interest not purchased by the Company at the price set forth in Section 17.2(e) below. If the Company and the Non-Withdrawing Members do not exercise their respective options in this Section 17.2(b), then the Withdrawing Member's Interests shall remain fully subject to all terms and conditions of this Agreement in the hands of the Withdrawing Member and all of its heirs, successors in interest and legal representatives.

(c) Transfers of Interests in Member. A Member that is not a natural person may not cause or permit an ownership interest, direct or indirect, in itself to be disposed of such that, after the disposition: (i) the Company would be considered to have terminated within the

meaning of Code Section 708; or (ii) without the prior written consent of the a Supermajority, such Member (the "Breaching Member") shall cease to be controlled by substantially the same Persons who control it as of the date of the Breaching Member's admission to the Company. For a period of one hundred twenty (120) days after the Company receives actual notice of any Member's breach of the provisions of clause (ii) of the immediately preceding sentence, the Company shall have the exclusive option to buy, and upon exercise of that option the Breaching Member shall sell, all of the Breaching Member's Units and Membership Interest, at the price determined in accordance with Section 17.2(e). The Breaching Member shall deliver documents satisfactory to the Company conveying its Interest free and clear of all liens, claims and encumbrances, any of which may be paid out of the purchase price, with the remainder, if any, paid to the Breaching Member. If the purchase price is insufficient to satisfy any such liens, the Breaching Member shall discharge the balance.

(d) Exercise of Options. The Company, the Non-Selling Members or the Non-Withdrawing Members, as the case may be, who exercise any option granted by this Section 17.2 or by Sections 17.5 or 17.6 shall do so by giving written notice (an "Exercise Notice") of the exercise of their respective options within the time periods provided in such Section to the Transferor or a Withdrawing Member or a Breaching Member, as the case may be. Such notice shall be effective upon the date provided in Section 22.1 hereof.

(e) Purchase Price and Terms.

(i) Purchase Price. If the Company or the Non-Withdrawing Members exercise their respective options in Section 17.2 (in such capacity, the "Optionor"), the purchase price which the Optionor shall pay for the Interest of the Withdrawing Member or the Breaching Member (in either case, referred to herein as the "Transferring Member") following the exercise of an option to purchase under Section 17.2(b) or Section 17.2(c) shall be an amount equal to the value of the Transferring Member's Interest as determined in this Section 17.2(e). The value of the Transferring Member's Interests shall be an amount that is mutually agreed upon by the Optionor and the Transferring Member. If they cannot agree within ten (10) days after the date of the final Exercise Notice, the purchase price shall be the amount which the Transferring Member would receive if all the Company's properties and assets were sold at their appraised fair market value and the proceeds were applied in accordance with Section 10.1(c) hereof, provided, however, that the assets of the Company shall be deemed to exclude the accounts of the Member which will no longer be managed by the Company following the purchase of such Units. An independent appraiser (a "Qualified Appraiser") experienced in conducting appraisals of assets similar to the Company property shall conduct an appraisal of all of the Company property to determine its fair market value (the "First Appraisal"). The Optionor shall select a Qualified Appraiser to perform the First Appraisal and shall assume the cost of the First Appraisal. If, within five (5) days after receipt of the First Appraisal, the Transferring Member disputes the value determined by the First Appraisal, the Transferring Member may obtain, at his, her or its own cost, a second appraisal (the "Second Appraisal") of the fair market value of the Company property by a Qualified Appraiser of its choice. If the parties agree, the Second Appraisal shall be used to determine the value of the Company property. If the two appraisals are performed and the parties cannot agree within ten (10) days which of the appraisals accurately reflects the value of the Company property, then

the parties shall have the option of either (A) obtaining, a third appraisal (the "Third Appraisal") to be performed by a Qualified Appraiser mutually agreeable to, and with fees paid one half by each of, the Transferring Member and the Optionor; or (B) submitting the matter to arbitration in accordance with Section 22.5.

(ii) Payment of Purchase Price and Closing. The closing of any sale and purchase of the Transferring Member's Interest in the Company shall be within thirty (30) days from the later of (1) the date of the final Exercise Notice; or (2) delivery of the final appraisal performed pursuant to Section 17.2(e)(i). The Optionor shall pay the purchase price in four equal installments, with the first installment payable at the closing and the next three installments payable on the first, second and third year anniversaries of such closing. At the Transferring Member's option, the Optionor will deliver a promissory note for the balance of the purchase price at the closing. No interest will accrue on the unpaid balance of the purchase price. The Transferring Member shall deliver documents satisfactory to the Optionor conveying its Units and Membership Interest free and clear of all liens, claims and encumbrances, any of which may be paid out of the purchase price, with the remainder, if any, paid to the Transferring Member. If the purchase price is insufficient to satisfy any such liens, the Transferring Member shall discharge the balance.

(f) Requirements for Transfer. Notwithstanding anything to the contrary in this Agreement, the Transfer of any Units or part thereof shall be subject to any restrictions on transferability required by law (including the Securities Act of 1933, any state securities or "Blue Sky" law, and the rules promulgated thereunder). Furthermore, no Transfer shall be effective unless and until all of the following requirements are satisfied: (i) the transferee is a citizen and resident of the United States, and otherwise not a tax-exempt entity under Section 168(h) of the Code; (ii) the transferor delivers to the Company an opinion of counsel, in form and substance satisfactory to counsel designated by the Company that neither the Transfer nor any offering in connection therewith violates any provision of any federal or state securities law or rules promulgated thereunder; (iii) the transferee executes a statement that he is acquiring such Units or such part thereof for his, her or its own account for investment and not with a view to distribution, fractionalization or resale thereof; (iv) the written acceptance and adoption by the transferee of the provisions of this Agreement including a representation and warranty that the representations and warranties in Section 17.4 are true and correct with respect to the transferee; (v) the transferee's payment of a transfer fee sufficient to cover all expenses of the Company connected with such Transfer; and (vi) the Transfer would not result in the termination of the Company (within the meaning of Section 708(b) of the Code) or the termination of its status as a partnership under the Code. The Transfer by a Member of all or part of his, her or its Units shall become effective on the day (the "Transfer Date") in which all of the requirements of this Section 17.2 have been met; provided, however, that the Company may elect to waive the delivery of the opinion of counsel and the payment of a transfer fee in his, her or its sole discretion. All distributions prior to the Transfer Date shall be made to the transferor and all distributions made thereafter shall be made to the transferee.

(g) HUD Consent. The parties acknowledge that certain facilities to be owned by its direct or indirect subsidiaries and affiliates may obtain a HUD-insured first mortgage loans from a commercial lender (the "HUD Lender"). To the extent the foregoing occurs, any Transfers or changes in the ownership interests of the Company with respect to the HUD

Facilities is expressly conditioned upon approval by HUD and the HUD Lender ("HUD Consents") and no such Transfer shall be effective prior to receipt of the HUD Consents.

(h) Operating Rules. If the Company and more than one Member constitute the "Optionor" for purposes of Section 17.2(e), then a Supermajority will determine any deadlock or other dispute among them concerning a decision required to be made hereunder by the Optionor. If more than one Member exercises its right to make a purchase of an Interest under this Section 17.2 with respect to any single Transfer subject thereto, then each exercising Member shall participate in the purchase of a proportionate part of such Interest in the same proportion as the number of Units then owned by such exercising Members bears to the number of Units then owned by all such exercising Members.

17.3 Substituted Members. Following a Transfer that complies with the requirements of Section 17.2 and the other provisions hereof, to the extent such requirements have not been waived by a Supermajority, the assignee or transferee of all or part of a Member's Units may be admitted to the Company as a Member in the place and stead of, or together with, as the case may be, the Member who has assigned or transferred all or part of his, her or its Units, but only upon satisfaction of all of the following conditions:

(a) A duly executed and acknowledge written instrument of transfer approved by the Company setting forth (i) the intention of the transferee to be admitted as a Member; (ii) the notice address of the transferee; and (iii) the number of Units transferred by the transferor to the transferee;

(b) The transferor and transferee execute and acknowledge all instruments and provide such other evidence as the Company may reasonably deem necessary or desirable to effect such admission; and

(c) The admission is approved by a Supermajority, which consent may be granted or withheld in the sole discretion of the Supermajority.

Upon satisfaction of all of the foregoing conditions and the admission of the assignee as a Member, the Company shall be authorized to amend this Agreement and any Exhibits thereto to reflect such admission. Alternatively, if any of the conditions above are not satisfied and the transferee of a Membership Interest is not admitted as a Member, the Transferee shall be considered the holder of an Economic Interest, entitled to receive the allocations and distributions attributable to the Transferred Interest, but shall not be entitled to inspect the Company's books and records, receive an accounting of Company financial affairs, exercise voting rights, if any, of the transferor Member, or otherwise take part in the Company's business or exercise the rights of a Member under this Agreement.

17.4 Drag Along. Notwithstanding anything in this Article XVII or otherwise in this Agreement to the contrary, if a Majority Interest desires to sell its or their Units and receives a "bona fide offer" from a third party to acquire all, but not less than all, of the outstanding Units of the Company, the Majority Interest shall have the right to sell all, but not less than all, of its Units and to require any remaining Members to sell all of their Units to the proposed transferee on the same terms and conditions stated in the offer provided, however, that if the remaining Members

are Class A Members, they shall have the right to receive accrued but unpaid Preferred Return with respect to their Units in addition to the purchase price proposed in the offer as a condition to the exercise of the rights of the Majority Interest contained in this Section 17.4. The Majority Interest shall deliver to the Company and each remaining Member a written notice stating all of the terms and conditions of the offer together with a copy of the offer or letter of intent and that the Majority Interest wishes to exercise its right under this Section 17.4. The Majority Interest may exercise its right under this Section 17.4 without complying with Section 17.2 of this Agreement, and no Member shall have a Right of First Refusal otherwise provided for in the Article XVII or elsewhere in this Agreement. Upon exercise of right under this Section 17.4, each Member shall take all steps necessary and sign all documents requested by the Majority Interest to cause the sale of each such Member's Units to be consummated as required pursuant to the terms and conditions of the bona fide offer and this Section 17.4.

ARTICLE XVIII

DISSOLUTION OF THE COMPANY

18.1 Events of Dissolution. The happening of any of the following events shall cause an immediate dissolution of the Company:

(a) Determination of the Unanimous Member Approval;

(b) entry of a decree of judicial dissolution; or

(c) administrative dissolution BY LAW.

18.2 Winding Up. In the event of the dissolution of the Company for any reason a liquidator or a liquidating committee selected by a Supermajority, shall wind up the affairs of the Company. The Members shall continue to share the Net Profits and Net Losses during the period of liquidation in the same proportion as before the dissolution. The liquidator or liquidating committee subject to approval of a Supermajority, based upon the plan set forth by the Company, shall have full right and, discretion granted to him to determine the time, manner and terms of any sale or sales of Company assets pursuant to such liquidation.

18.3 Distribution of Liquidation Proceeds. Following the payment of all debts and liabilities of the Company and all expenses of liquidation and subject to the right of the liquidator or liquidating committee to set up such Reserves as reasonably necessary for any contingent or unforeseen liabilities or obligations of the Company, the proceeds of the liquidation and any other funds of the Company shall be distributed in accordance with Section 10.1(c) hereof.

18.4 Limitation on Distribution Rights Upon Dissolution. Each Member shall look solely to the assets of the Company for all distributions with respect to the Company and for the return of any unpaid portion of his, her or its Capital Contribution and shall have no recourse therefor against any other Member. No Member shall have any right to demand or receive property other than cash upon dissolution and termination of the Company or, except with respect to the

Preferred Return, to demand the return of any part of the Capital Contributions prior to dissolution and termination of the Company.

18.5 Dissolution Documents. Upon the dissolution and the commencement of winding up of the Company, the Company shall have the authority to execute and record Articles of Dissolution of the Company as well as any and all other documents required to effectuate the dissolution and termination of the Company.

ARTICLE XIX

AMENDMENT OF AGREEMENT AND ARTICLES OF ORGANIZATION

Except as otherwise provided in the Act, this Agreement or the Articles may be amended upon the affirmative vote of a Supermajority Interest.

ARTICLE XX

ISSUANCE OF NEW UNITS AND ADMISSION OF NEW MEMBERS

20.1 Approval Requirements. The issuance of new Units of any class and the terms and conditions of any such issuance must be approved by a Supermajority Interest. The holders of any newly issued Units (other than the existing Members) shall be admitted as a Member upon such terms and conditions as a Supermajority Interest may determine, consistent with this Agreement, the Articles and any applicable provision of law.

20.2 Allocations to New Members. No new Member shall be entitled to any retroactive allocation of any item of income, gain, loss, deduction or credit of the Company.

ARTICLE XXI

CERTAIN REPRESENTATIONS OF CLASS A and CLASS C MEMBERS; HUD PROVISIONS

21.1 Class A and C Member Representations. The Class A and Class C Members, for itself and for its direct and indirect equity owners, members, partners, shareholders, director hereby represents and warrants to the Company:

(a) It has reviewed such financial information, including without limitation those relating to the proposed acquisition and books and records of the Company as it deems necessary or appropriate, and has had the opportunity to ask any questions about the Company and the proposed acquisition to its complete satisfaction.

(b) It is an "accredited investor" within the meaning of Regulation D under the 1933 Act; has knowledge and experience in financial and business matters such that it is capable of evaluating the merits and risks of owning the Membership Interest or its Interest. It is holding its Units for its own account, for investment purposes only and not with a view to, and with no present intention of, selling or distributing the same.

(c) It understands the risks associated with investment in the Company and can bear the risk of losing its whole investment. It understands that health care facilities are highly regulated and subject to regulatory reform.

(d) It understands that the Company is relying on third party advisors in the conduct of due diligence with respect to its investments and has not made independent evaluation.

21.2 Certain HUD Requirements. For such period of time as the Company or any of its direct or indirect subsidiary entities is seeking approval or is approved as a HUD-mortgagee or correspondent, then the following provisions shall apply:

(a) such representative selected by a Supermajority shall have exclusive authority to deal with HUD;

(b) prior to any change in the Members, the Company shall notify HUD to the extent a HUD loan is then in existence of the change and the new Member shall satisfy all of the requirements of this Agreement and of HUD;

(c) the Members shall ensure that all employees and officers of the Company meet all requirements of HUD (including, without limitation, the requirements set forth in HUD Mortgagee Approval Handbook 4060.1 REV-1, as revised from time to time); and

(d) the Members shall report all changes in the business of the Company as may be required by the rules and regulations of HUD to be reported from time to time.

ARTICLE XXII

MISCELLANEOUS

22.1 Notices. All notices and demands required or permitted under this Agreement shall be in writing and may be sent by overnight courier or personal delivery, if to the Company at the Company's principal place of business, and if to any Member, to the Member at the Member's address as shown in this Agreement or as otherwise provided from time to time in the records of the Company. Any Member may specify a different address by notifying the Company in writing of such different address. Such notices addressed as provided herein shall be deemed given the day after deposit with an overnight courier, or when delivered in person, as the case may be.

22.2 Entire Agreement. This Agreement constitutes the entire agreement between the parties relating to the subject matter hereof. It supersedes and overrides any prior agreement or understandings, whether oral or written, between any or all of the parties hereto relating to the subject matter hereof, including without limitation, the terms of the issuance of Units in the

Company. This Agreement may not be modified or amended in any manner other than as set forth herein.

22.3 Tax Matters Partner _____ is designated the "Tax Matters Partner" (as defined in section 6231 of the Code), and is authorized and required to represent the Company (at the Company's expense) in connection with all examinations of the Company's affairs by tax authorities, including, without limitation, administrative and judicial proceedings, and to expend Company funds for professional services and costs associated therewith. The Members agree to cooperate with each other and to do or refrain from doing any and all things reasonably required to conduct such proceedings. In particular, and not by way of limitation, the Tax Matters Partner is authorized to file on behalf of the Company any "safe harbor election" authorized by the Treasury Regulations with regard to the valuation of compensatory transfers of interests in the Company.

22.4 Governing Law. This Agreement and the rights of the parties hereunder shall be governed by and interpreted in accordance with the laws of the State of New York.

22.5 Dispute Resolution. The Members and the Company hereby irrevocably agree to submit any dispute to Arbitration of their choosing which may include a Jewish Rabbinical Court should both parties agree. Notwithstanding the foregoing, should the parties not otherwise agree, such arbitration shall be before a single arbitrator for the American Arbitration Association in New York City. Such Arbitration shall be binding.

22.6 Successors and Assigns. Except as herein otherwise specifically provided, this Agreement shall be binding upon and inure to the benefit of the parties and their legal representatives, heirs, administrators, executors, successors and permitted assigns.

22.7 Captions. Captions contained in this Agreement are inserted only as a matter of convenience and in no way define, limit or extend the scope or intent of this Agreement or any provision thereof.

22.8 Severability. If any provision of this Agreement, or the application of such provision to any person or circumstances shall be held invalid, the remainder of this Agreement, or the application of such provision to persons or circumstances other than those to which it is held invalid, shall not be affected hereby.

22.9 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

22.10 Number and Gender. Whenever the singular number is used in this Agreement and when required by the context, the name shall include the plural, and the masculine gender shall include the feminine and neuter genders.

22.11 Waiver of Partition. To the extent permitted by law, each of the Members irrevocably waives, during the term of the Company, and during the period of its liquidation following dissolution, any right that he may have to maintain any action for partition with respect to the assets of the Company.

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK -
SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Members have executed this Agreement as of the date first hereinabove set forth.

CLASS A MEMBERS:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

IN WITNESS WHEREOF, the Members have executed this Agreement as of the date first hereinabove set forth.

CLASS A MEMBERS:

By: _____
Name:

By: _____
Name:

By: _____
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By: _____
Name:

By: _____
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By: _____
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By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

IN WITNESS WHEREOF, the Members have executed this Agreement as of the date first hereinabove set forth.

CLASS A MEMBERS:

By: D. Kornzt
Name: Debbie Kornguir

By: [signature]
Name: Terry Lichtschein

By: ____________________
Name:

By: ____________________
Name:

By: ____________________
Name:

By: ____________________
Name:

By: ____________________
Name:

By: ____________________
Name:

By: ____________________
Name:

By: ____________________
Name:

By: ____________________
Name:

IN WITNESS WHEREOF, the Members have executed this Agreement as of the date first hereinabove set forth.

CLASS A MEMBERS:

By: _____
Name: Ephram Lahasky

By: _____
Name: ANDREW LANDA

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

IN WITNESS WHEREOF, the Members have executed this Agreement as of the date first hereinabove set forth.

CLASS A MEMBERS:

By: _____
Name: Ephram Lahasky

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

By: _____
Name:

EXHIBIT A

Units of Members

Name of Members	Percentages
Benjamin Landa	16.66%
Villages of Orleans LLC	20.99%
Ephraim Lahasky	16.66%
Sam Halper	12.33%
Terry Lichtshein	7.5%
Debbie Korngut	9.16%
Bernard Fuchs	3.32%
Joel Edelstein	3.32%
Gerald Fuchs	3.32%
Tova Fuchs	3.32%
Israel Freund	3.32%

EXHIBIT 6

OPERATING AGREEMENT

OF

TELEGRAPH REALTY LLC

A NEW YORK LIMITED LIABILITY COMPANY

OPERATING AGREEMENT
OF
TELEGRAPH REALTY LLC

THIS OPERATING AGREEMENT (the "Agreement") is entered into effective as of the 6th day of October, 2014 (the "Effective Date"), by and among TELEGRAPH REALTY LLC, a New York limited liability company (the "Company") and the parties identified as Members on **Exhibit A** attached hereto.

RECITALS

A. The Company was formed as a New York limited liability company on January 29, 2014, by the filing of Articles of Organization with the Secretary of State of the State of New York.

B. The Company and the Members desire to provide for certain agreements governing the business and affairs of the Company with and upon and conditions set forth in this Agreement.

ARTICLE I
FORMATION OF LIMITED LIABILITY COMPANY

1.1 By executing this Agreement or any counterpart thereof, each Member ratifies and approves the Articles of Organization as so filed and all amendments thereto filed on or before the date of the Member's execution of this Agreement.

1.2 The Company has been organized as a limited liability company and the Members intend that this Agreement shall serve as the Operating Agreement of the Company. The rights and liabilities of the Members shall be as provided by law, except as otherwise expressly provided in this Agreement.

1.3 The registered office of the Company shall be as designated by the Managing Member from time to time with approval of a Supermajority.

1.4 The Managing Member shall cause the Company to be qualified, formed or registered under assumed or fictitious name statutes or similar laws in any jurisdiction in which the Company conducts business and in which such qualification, formation or registration is required by law or deemed advisable by the Managing Member. The Managing Member, as an authorized person within the meaning of the Act, shall execute, deliver and file any certificates (and any amendments and/or restatements thereof) necessary for the Company to qualify to do business in a jurisdiction in which the Company may wish to do business. The Managing Member shall be authorized to designate on behalf of the Company a registered agent and a registered office (or their respective equivalent) as may be required by applicable law in each jurisdiction in which the Company is qualified, formed or registered.

1.5 It is the intent of the Members that the Company shall always be treated and operated in a manner consistent with treatment as a "partnership" for federal and state income tax purposes. No Member shall take any action inconsistent with such intent.

ARTICLE II

NAME

The business of the Company shall hereafter be conducted under the name "Telegraph Realty LLC", or such other name(s) as the Managing Member with approval of a Supermajority shall hereafter designate.

ARTICLE III

DEFINITIONS

The following terms used in this Operating Agreement shall have the following meanings (unless otherwise expressly provided herein):

"Act" means the Limited Liability Company Law of the Consolidated Laws of New York, Section 203, *et seq.*, as it may be amended from time to time, and any successor to said Statute.

"Adjusted Capital Contribution" means, as of any day, the aggregate Capital Contributions made by a Member (as well as by its Affiliates and prior Members from whom Units or Interests were acquired), reduced by all distributions of Distributable Cash to such Member which were intended or designated as the return of the Capital Contributions of such Member, including distributions pursuant to Sections 10.1(a)(ii) and 10.1(c)(iv) hereof.

"Affiliate" means, with respect to any Person: (a) any other Person directly or indirectly controlling, controlled by or under common control with the subject Person or (b) any officer, director, trustee, Managing Member, managing member or general partner of the subject Person, provided that, for the purposes of this definition, "control" (including, with correlative meanings, the terms "controlled by" and "under common control with"), as used with respect to any Person, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting securities, by contract or otherwise.

"Agreement" means this Operating Agreement, as amended, modified, restated or supplemented from time to time.

"Articles" means the Articles of Organization of the Company, as filed with the New York Secretary of State, as the same may be amended from time to time.

"Book Value" means, with respect to any Company property, the Company's adjusted basis for federal income tax purposes, except that:

(a) the initial Book Value of any asset contributed by a Member to the Company shall be the gross fair market value of the asset, as determined by the contributing Member and the Company;

(b) the Book Value of all the Company's assets shall be adjusted to equal their respective gross fair market values, as determined by the Managing Member, as of the following times: (i) the acquisition of an additional Membership Interest in the Company in exchange for more than a *de minimis* Capital Contribution; (ii) the distribution by the Company of more than a *de minimis* amount of property as consideration for an interest in the Company; and (iii) the liquidation of the Company within the meaning of Treasury Regulations Section 1.704-1(b)(2)(ii)(g); provided, however, that the adjustments pursuant to clauses (i) and (ii) above shall be made only if the Managing Member reasonably shall determine that the adjustments are necessary or appropriate to reflect the Members' relative economic interests in the Company;

(c) the Book Value of any Company asset distributed to a Member shall be the gross fair market value, taking Code Section 7701(g) into account, of the asset on the date of distribution; and

(d) the Book Value of Company assets shall be increased (or decreased) to reflect any adjustments to the adjusted basis of the assets pursuant to Code Section 734(b) or Code Section 743(b), but only to the extent that the adjustments are taken into account in determining Capital Accounts pursuant to Treasury Regulations Section 1.704-1(b)(2)(iv)(m).

If the Book Value of an asset has been determined or adjusted pursuant to paragraph (a), (b) or (d) immediately above, then the Book Value shall thereafter be adjusted by the Depreciation taken into account with respect to the asset for purposes of computing Net Profits and Net Losses.

"Capital Account" as of any given date shall mean the account established and maintained by the Company for each Member, as determined and adjusted up to the date in question pursuant to Article VIII hereof.

"Capital Contribution" shall mean any contribution to the capital of the Company in cash or property by a Member, whenever made. "Initial Capital Contribution" shall mean the initial contributions to the capital of the Company by the Members pursuant to Section 8.1 of this Agreement.

"Class A Members" shall mean the Members designated as Class A Members on Exhibit A hereto and who have met the requirements to become a Member under this Agreement.

"Code" shall mean the Internal Revenue Code of 1986, as amended, or the corresponding provisions of subsequently enacted federal revenue laws.

"Company" means Telegraph Realty LLC, which has been formed by the filing of the Articles pursuant to the Act and is governed by the Articles and this Agreement, as said entity may from time to time be constituted.

"Depreciation" means, for each fiscal year or other period, an amount equal to the depreciation, amortization, or other cost recovery deduction allowable with respect to an asset for the year or other period, except that if the Book Value of an asset differs from its adjusted basis for federal income tax purposes at the beginning of a year or other period, Depreciation shall be an amount which bears the same ratio to the beginning Book Value as the federal income tax depreciation, amortization, or other cost recovery deduction for the year or other period bears to the beginning adjusted tax basis; provided, however, that if the federal income tax depreciation, amortization, or other cost recovery deduction for the year is zero, Depreciation shall be determined with reference to the beginning Book Value using any reasonable method selected by the Managing Member with approval of a Supermajority.

"Distributable Cash" shall mean all cash, revenues and funds received by the Company from Company operations, less the sum of the following to the extent paid or set aside by the Company: (a) all payments of principal, interest and other sums due on loans or indebtedness incurred by the Company; (b) all cash expenditures incurred or accrued incident to the normal operation of the Company's activities; (c) all fees and expenses due to the Members and their Affiliates, including without limitation those set forth in Section 10.2 hereof, but excluding the fees described in Section 10.2(b) and 10.2(c) hereof; and (d) such Reserves as the Managing Member deems reasonably necessary for the proper operation of the Company's business.

"Economic Interest" means a share of one or more of the Company's Net Profits, Net Losses, Distributable Cash, and the other assets of the Company, pursuant to this Agreement and the Act, but shall not include any right to participate in the management or affairs of the Company nor the right to vote on, consent to, or otherwise participate in any decision of the Members or the Managign Member. Economic Interests may be evidenced by Units and shall be considered intangible personal property for purposes of applicable law and this Agreement.

"Fiscal Year" shall mean the Company's fiscal year, which shall be the calendar year as set forth in Article XII hereof.

"HUD" shall mean the United States Department of Housing and Urban Development.

"Majority Interest" shall mean the Member or Members (or such Members' designees) holding that number of Units of any Class when taken together, exceed fifty percent (50%) of the aggregate of all Units of any Class then outstanding and held by Members.

"Managing Member" shall mean Ephram Lahasky, or such other entity or individual(s) elected or designated as Managing Member by a Supermajority as provided herein, who shall be authorized to manage and direct the affairs of the Company as provided in this Agreement but only to the extent consistent with law.

"Member" shall mean each Person who executes a counterpart of this Operating Agreement as a Member and each Person who may hereafter become a Member of the Company. "Members" shall refer to all Members, regardless of the Class of the Membership Interests, unless otherwise expressly provided herein.

"Membership Interest" shall mean a Member's entire interest in the Company, including the Member's share of the Net Profits, Net Losses, Distributable Cash and other assets of the

Company, and such other rights and privileges that the Member may enjoy by being a Member, all of which shall be evidenced by Units. A Membership Interest and the Units evidencing the Interest may be designated as "Class A", "Class B" or another Class as provided elsewhere in this Agreement, and the Member who holds such Membership Interest and Units shall have the rights of such Class and shall be subject to the limitations of such Class, all as described in this Agreement. A Membership Interest shall constitute intangible personal property for all purposes under applicable law and this Agreement.

"Net Losses" shall mean, for each Fiscal Year, the losses and deductions of the Company determined in accordance with accounting principles consistently applied from year to year employed under the accrual method of accounting and as reported, separately or in the aggregate, as appropriate, on the Company's information tax return filed for federal income tax purposes, plus any expenditures described in Section 705(a)(2) (B) of the Code.

"Net Profits" shall mean, for each Fiscal Year, the income and gains of the Company determined in accordance with accounting principles consistently applied from year to year employed under the accrual method of accounting and as reported, separately or in the aggregate, as appropriate, on the Company's information tax return filed for federal income tax purposes, plus any income described in Section 705(a)(1)(B) of the Code.

"Percentage Interest" shall mean, as of a particular date, the proportion that a person's aggregate Units of any class bears to the aggregate number of all issued and outstanding Units, as measured on the specified date. The Percentage Interests may be adjusted from time to time upon the issuance or redemption of Units or as otherwise required in this Agreement.

"Person" shall mean any individual, general or limited partnership, limited liability company, corporation, joint venture, trust, business trust, estate, cooperative or association or any foreign trust or foreign business organization, and their heirs, executors, administrators, legal representatives, successors and assigns where the context so permits.

"Preferred Return" means as to Class A Member, a cumulative return on such Class A Member's average daily Unrecovered Capital Contributions, non-compounded, at a rate per annum equal to the Prime Lending Rate plus 3% as published by the Wall Street Journal on January, 1 of the year in question.

"Property" shall mean any real, personal or intangible property now or hereafter acquired by the Company.

"Reserves" shall mean, with respect to any fiscal period, funds set aside or amounts allocated during such period to reserves which shall be maintained in amounts deemed sufficient by the Managing Member for working capital, to pay taxes, insurance, debt service or other costs or expenses incident to the operation of the Company's business, for liabilities of the Company not yet due, and/or future or contingent liabilities of the Company, including without limitation, such reserves as may be required by HUD or any lender.

"Supermajority" shall mean (i) the affirmative vote or consent of 75% of all Class A Members (or their respective designees) of the Company or their designee.

"Transfer" means, whether capitalized or not capitalized, the sale, assignment, gift, transfer, withdrawal, mortgage, pledge, hypothecation, exchange or other disposition of any part or all of a Member's Membership Interest, whether voluntarily, by operation of law, or otherwise.

"Treasury Regulations" shall include proposed, temporary and final regulations promulgated under the Code in effect as of the date of filing the Articles and the corresponding sections of any regulations subsequently issued that amend or supersede such regulations.

"Unanimous Member Approval" "Unanimous Approval" of "Unanimous Approval of the Members" shall mean the affirmative vote or consent of all Class A Members (or their respective designees) of the Company.

"Unrecovered Capital Contributions" shall mean, with respect to any Class A Member at any time, the aggregate Capital Contributions made by such Member in cash or property up to such time, plus the Preferred Return but less the aggregate distributions theretofore received by such Member pursuant to Section 10.1(a)(i).

"Unit" means the evidence of a Membership Interest or an Economic Interest in the Company, which shall be designated as belonging to a particular class of Units and which will have the rights and limitations described in this Agreement for all outstanding Units of the same class.

"Withdrawal" means, with respect to any Member, the death or bankruptcy of such Member or a complete disposition of such Member's entire Interest in the Company made during the lifetime (or other existence) of such Member.

ARTICLE IV

PURPOSES

The purpose of the Company shall be to acquire and hold membership interests in business entities that hold real property of skilled nursing facilities, senior living facilities, or ancillary businesses related thereto, and to do anything and all things permitted by the Act and by law. The Company shall possess and may exercise all powers and privileges granted by law, or by the Agreement, including incidental powers thereto, to the extent that such powers and privileges are necessary, customary, convenient or incidental to the attainment of the Company's purposes.

ARTICLE V

MEMBERS AND UNITS

5.1 Members. The names and mailing addresses of the Members, the number and class of their Units, and their initial Percentage Interests shall be set forth respectively in the attached Exhibit A. Such Exhibit A shall be amended by the Managing Member from time to time upon the admission of new Members, the issuance of additional Units, or the payment of Additional Capital Contributions. The Company may treat the Person in whose name any Unit shall be registered on the books and records of the Company as a Member and the sole holder of

such Unit for all purposes whatsoever and, accordingly, shall not be bound to recognize any equitable or other claims to or interest in such Unit on the part of any other Person, whether or not the Company shall have actual or other notice thereof.

5.2 Units. Initially, the Company shall be authorized to issue one class of Membership Interests to its Members - "Class A Units".

(a) Class A Units. Class A Units will initially be held by Ephram Lahasky, Josh Farkovits, David Gast and any other persons designated as Class A Members on Exhibit A, subject to such persons fulfilling the requirements to become a Member hereunder including in the case of all Class A members, the timely funding of their initial capital contribution in its entirety. Class A Members will contribute capital to the Company as provided in this Agreement. No person other than those who are Class A Members at the time of formation can become Class A Members except to the extent that a Class A Member transfers the same to a spouse, or child or a trust for the benefit of the foregoing.

(b) Class B Units. Class B Units are reserved. The Class B Member has or will contribute capital to the Company as provided in this Agreement and shall only have the voting rights set forth herein.

(c) Class C Units. Class C Units are reserved. The Class C Members will contribute capital as required of Class A Members, but shall have no Voting rights.

(d) Additional Classes of Units. The Managing Member may authorize from time to time the issuance of additional classes of Units, with such rights and limitations as shall be approved by a Supermajority.

ARTICLE VI

TERM

The term of the Company commenced on the date that the Articles were filed in the office of the Secretary of State of the State of New York (the "Formation Date") and shall continue perpetually, unless and until the Company is dissolved in accordance with the provisions of either this Agreement or applicable law.

ARTICLE VII

PRINCIPAL PLACE OF BUSINESS

The principal place of business of the Company shall be located at 600 Broadway, Lynbrook, NY , or such other place as the Managing Member may designate and is approved by a Supermajority. The books and records of the company shall be located at 600 Broadway, Lynbrook, NY, or such other place as the Managing Member may designate and is approved by a Supermajority.

ARTICLE VIII

CAPITAL CONTRIBUTIONS

8.1 Initial Capital Contributions.

(a) Class A Member. On or before the Effective Date, the Class A Member shall contribute to the Company, as its Initial Capital Contributions, cash in such amounts set forth on Exhibit A. Failure to contribute the foregoing on or before the date specified shall be a bar to Membership even if such funds are subsequently received. Any property contributed to the Company by the Class A Member shall have a Book Value equal to its fair market value, as mutually agreed upon by the contributing Class A Member and the Managing Member. In exchange for such Initial Capital Contributions the Company shall issue Class A Units to the Class A Members in the amount set forth in Exhibit A attached hereto.

8.2 Additional Capital Contributions. If the Managing Member and a Majority determines or a Supermajority, with or without the consent of the Managing Member, determines that additional capital beyond the Initial Capital Contribution is necessary for the ongoing operation of the business of the Company, capital improvements or the like, then additional capital may be raised by the Managing Member through additional Capital Contributions from the Class A (and Class C) Members in an amount. Additional Capital Contributions would be used to fund the ongoing working capital of the Company or such other uses as the Managing Member may determine upon a vote of a Supermajority. In exchange for such additional capital contribution (beyond the Initial Contribution) from the Class A Members, the Class A Member will receive no additional Units. Thereafter, if the Managing Member or a Supermajority, each with consent required herein, determines that additional capital beyond such Capital Contributions is required, then additional capital shall be raised by the Managing Member through additional Capital Contributions from the Class A Members. The Managing Member may require from the Class A Members additional Capital Contributions in such amounts and at such times as shall be stated in a written notice to the Class A Members (the "Notice"), provided that all such requests shall be made to all Class A Members in proportion to their Units at the time of the request. If a Member does not make timely payment of its full share of any additional Capital Contribution as requested in the Notice (a "Default Member"), then the other Members who have timely contributed their full share of the requested contribution (a "Contributing Member") shall have the right, but not the obligation, to (i) loan to the Company any funds (and funds that any Member may have forwarded pursuant to the Notice shall not be an additional capital contribution but will be part of the loan) specified in the Notice which were requested but not contributed by the Default Member (a "Rescue Loan") at a rate of interest equal at all times to 5% per annum over the "Base Rate" (or prime rate or similar equivalent rate) of interest from time to time in effect established by JPMorgan Chase Bank, and announced by it as the rate charged by it to its prime commercial customers on short-term unsecured borrowings (the "Prime Rate"), provided that such interest rate shall not exceed the maximum rate of interest permitted by applicable law or (ii) contribute the same as additional capital of the contributing member and dilute the shares of the noncontributing or underfunded Member(s). Dilution shall be an absolute right. Whenever more than one Contributing Member wishes to make a Rescue Loan for the same purpose, the Rescue Loans shall be made in equal amounts, or in such other proportions as the Contributing Members wishing to make the Rescue Loans shall agree, and such Rescue Loans shall be *pari passu* in priority. Each such Rescue Loan shall be due and payable as to all outstanding principal and accrued and unpaid interest on the first anniversary of

the date on which the loan is advanced; provided however, that interest on Rescue Loans shall be due and payable quarterly, prior to any distributions to any Members, on a first-in, first-out basis, but taking into account Rescue Loans which are or are deemed *pari passu* in priority. All Distributable Cash shall be applied to the repayment of principal of Rescue Loans on a first-in, first-out basis, but taking into account Rescue Loans which are or are deemed *pari passu* in priority. Rescue Loans which are not *pari passu* in priority shall have priority against each other as to payment of interest and then of principal on a first-in, first-out basis. All of the aforesaid Rescue Loans will be obligations of the Company and of the other Members personally up to the amount that they were required to contribute. Should any Rescue Loan not be repaid within a period of One Year from the date of issue, the Member(s) providing such Rescue Loan(s) shall have the option of converting the same to equity by diluting the shares of the non-contributing Members, upon 30 days written notice to Company and the non-contributing or underfunded Member(s). Member shall have no right to prevent such conversion, even if they attempt to make a contribution to cover repayment of the Rescue Loan after notice is tendered.

8.3 Loans to Company. With the prior approval of the Managing Member and a Supermajority, a Member may lend to the Company such funds as the Managing Member reasonably requires for the continuation of its business operations and activities. Such loans shall be made on such terms and conditions that are approved by a Supermajority and shall, unless decided by Unanamous vote, otherwise shall be on terms that are economically similar to what is available in the commercial or private markets after reasonable inquiry of institutional lenders, investment bankers and or private lenders for loans with equivalent size, credit and collateral.

8.4 Capital Accounts.

(a) A separate Capital Account will be maintained for each Member. Each Member's Capital Account will be increased by (1) the amount of money contributed by such Member to the Company; (2) the agreed fair market value of Property contributed by such Member to the Company (net of liabilities secured by such contributed Property that the Company is considered to assume or take subject to under Section 752 of the Code); and (3) the amount of Net Profits allocated to such Member. Each Member's Capital Account will be decreased by (1) the amount of money distributed to such Member by the Company; (2) the agreed fair market value of Property distributed to such Member by the Company (net of liabilities secured by such distributed Property that such Member is considered to assume or take subject to under Section 752 of the Code); and (3) the amount of Net Losses allocated to such Member.

(b) For purposes of computing the amount of any item of Company income, gain, loss or deduction to be reflected in the Members' Capital Accounts and to be allocated pursuant to this Agreement, the determination, recognition and classification of any such item shall be the same as its determination, recognition and classification for federal income tax purposes (including any method of depreciation, cost recovery or amortization used for this purpose), provided that:

(i) The computation of all items of income, gain, loss and deduction shall include income and expense of the Company that is exempt from federal income tax

and also those items described in Code Section 705(a)(1)(B) or Treasury Regulations Section 1.704-1(b)(2)(iv)(i), without regard to the fact that such items are not includible in gross income or deductible for federal income tax purposes;

(ii) If the Book Value of any Company Property is adjusted pursuant to paragraphs (b) or (c) of the definition of "Book Value" set forth in this Agreement, the amount of such adjustment shall be taken into account as gain or loss from a disposition of such Property;

(iii) Items of income, gain, loss or deduction attributable to the disposition of Company Property having a Book Value that differs from its adjusted basis for federal income tax purposes shall be computed by reference to the Book Value of such Property; and

(iv) Items of Depreciation with respect to Company Property having a Book Value that differs from its adjusted basis for federal income tax purposes shall be computed by reference to the Book Value of such property in accordance with Treasury Regulations Section 1.704-1(b)(2)(iv)(g).

(c) In the event of a permitted Transfer of Membership Interests pursuant to Article XVII hereof, the Capital Account of the Transferring Member shall become the Capital Account of the transferee to the extent it relates to the transferred Membership Interest in accordance with Section 1.704-1(b)(2)(iv) of the Treasury Regulations.

(d) The manner in which Capital Accounts are to be maintained pursuant to this Agreement is intended to comply with the requirements of Code Section 704(b) and the Treasury Regulations promulgated thereunder. If, in the opinion of the Managing Member, with the advice of the Company's counsel, the manner in which Capital Accounts are to be maintained pursuant to the preceding provisions of this Section 8.4 should be modified in order to comply with Section 704(b) of the Code and the Treasury Regulations, then notwithstanding anything to the contrary contained in the preceding provisions of this Section 8.4, the method in which Capital Accounts are maintained shall be so modified.

(e) Except as otherwise required by law, no Member shall have any liability or obligation, whether to the Company, to another Member or to any other person, to restore all or any portion of a deficit balance in such Member's Capital Account to the extent such Member is otherwise in compliance with the terms of this Agreement.

8.5 Interest on and Return of Members' Capital Contributions. No Member has the right to demand and receive interest on his, her or its Capital Contributions or a return of his, her or its Capital Contribution, except as otherwise specifically provided in this Agreement.

8.6 Liability of Members. Except as required under the Act or any other provision of this Agreement, no Member shall have any personal liability for debts or other obligations of the Company, including, without limitation, obligations for local, state and federal taxes.

ARTICLE IX

ALLOCATIONS OF NET PROFITS AND LOSSES

9.1 Allocations.

(a) After giving effect to the special allocations set forth in Section 9.2, the Company's Net Profits, if any, and the Company's Net Losses, if any, for each Fiscal Year or other accounting period shall be allocated among the Members in a manner that will, as nearly as possible, cause the capital account balance of each such Member at the end of such accounting period to equal the hypothetical distribution, if any, that such Member would receive if, on the last day of such period: (x) all of the Company's assets, including cash, were sold for cash equal to their book values (as determined for purposes of maintaining capital accounts in accordance with Section 8.4 hereof), taking into account any adjustments thereto for such period; (y) all Company liabilities reflected on the face of the Company's balance sheet were satisfied in cash according to their terms (limited, with respect to each nonrecourse liability, to the book value (as so determined) of the Company assets securing such liability) and (z) the net remaining proceeds thereof were distributed in full to the Members in the order of priority described in Section 10.1(c).

(b) The Members intend that the allocations of Net Profits and Net Losses under this Agreement will produce final capital account balances of each Member equal to the aggregate amount of liquidating distributions to which such Member will be entitled under Section 10.1(c) hereof. If such allocation provisions would fail to produce such final capital account balances, (i) such allocation provisions may be amended by Managing Member if and to the extent necessary to produce such result, and (ii) Net Profits and Net Losses (or items of gross income, gain, loss and deduction, if necessary) for prior Fiscal Years for which amended tax returns may still be filed may be reallocated among the Members to the extent it is not possible to achieve such result with allocations of such items for the current and future Fiscal Years.

(c) Other Items. Any other item of income, gain, loss, expense or credit in any Fiscal Year which is not covered by the preceding provisions of this Section 9.1 or elsewhere in this Article IX shall be allocated among the Members in accordance with their Percentage Interests as they exist from time to time during such Fiscal Year.

(d) New Members. If any new Member is admitted to the Company, a Supermajority shall determine the appropriate adjustments to make to this Section 9.1 as well as Section 9.2, and in accordance with Section 706 of the Code, whether to prorate items of income and deduction according to the portion of the year for which such person was a Member of the Company or whether to close the books of the Company on an interim basis and divide the Fiscal Year into two or more segments.

(e) Economic Interests. The allocations and other provisions of this Article IX shall apply to any holder of any Economic Interest in the Company, effective upon the date of acquisition of such Economic Interest and without regard to whether such holder is admitted as a Member.

9.2 Special Allocations. The following special allocations shall be made in the following order:

(a) Minimum Gain Chargeback. Notwithstanding any other provision of this Article, if there is a net decrease in Company minimum gain during any Fiscal Year, each Member shall be specially allocated items of Company income and gain for such year (and, if necessary, subsequent years) in an amount equal to that Member's share of the net decrease in Company minimum gain (within the meaning of Treasury Regulations Section 1.704-2(g)(2)). Allocations pursuant to the previous sentence shall be made in proportion to the respective amounts required to be allocated to each Member pursuant thereto. This Section is intended to comply with the minimum gain chargeback requirement in Treasury Regulations Section 1.704-2(f) and shall be interpreted consistently therewith.

(b) Member Minimum Gain Chargeback. Notwithstanding any other provision of this Article, except as provided in Section 9.2(a), if there is a net decrease in Member minimum gain attributable to a Member nonrecourse debt during any Fiscal Year, each Member who has a share of the Member minimum gain attributable to such Member nonrecourse debt, determined in accordance with Treasury Regulations Section 1.704-2(i)(5) shall be specially allocated items of Company income and gain for such year (and if necessary, subsequent years) in an amount equal to the Person's share of the net decrease in Member minimum gain attributable to such Member nonrecourse debt, determined in accordance with Treasury Regulations Section 1.704-2(i)(4). Allocations pursuant to the previous sentence shall be made in proportion to the respective amounts required to be allocated to each Member pursuant thereto. This Section is intended to comply with the minimum gain chargeback requirement in Treasury Regulations Section 1.704-2(i)(4) and shall be interpreted consistently therewith.

(c) Qualified Income Offset. Notwithstanding anything in this Article, if a Member unexpectedly receives an adjustment, allocation or distribution described in Treasury Regulations Section 1.704-1(b)(2)(ii)(d)(4), (5) or (6), and such unexpected adjustment, allocation or distribution puts such Member's Capital Account into a deficit balance or increases such deficit balance, such Member shall be allocated items of income or gain of the Company in an amount and manner sufficient to eliminate such deficit as quickly as possible, provided that an allocation pursuant to this Section 9.2(c) shall be made if and only to the extent that such Member would have a deficit balance in the Member's Capital Account after all other allocations provided for in Section 9.2 have been tentatively made as if this Section 9.2(c) were not in the Agreement. It is intended that this Section 9.2(c) shall meet the requirement that this Agreement contain a "qualified income offset" as defined in Treasury Regulations Section 1.704-1(b)(2)(ii)(d) and this Section shall be interpreted and applied consistently therewith.

(d) Gross Income Allocation. In the event any Member has a deficit Capital Account at the end of any Fiscal Year which is in excess of the sum of (i) the amount such Member is obligated to restore pursuant to any provision of this Agreement, and (ii) the amount such Member is deemed to be obligated to restore pursuant to the penultimate sentences of Treasury Regulations Sections 1.704-2(g)(1) and 1.704-2(i)(5), each such Member shall be specially allocated items of gross income of the Company in the amount of such excess as quickly as possible, provided that an allocation pursuant to this Section 9.2(d) shall be made only if and to the extent that such Member would have a deficit Capital Account in excess of such sum after all other allocations provided for in this Article have been made as if Section 9.2(c) and this Section 9.2(d) were not in the Agreement.

(e) Nonrecourse Deductions. Nonrecourse deductions for any Fiscal Year or other period shall be specially allocated to the Members in accordance with their respective Percentage Interests.

(f) Member Nonrecourse Deductions. Any Member nonrecourse deductions for any Fiscal Year or other period shall be specially allocated to the Member who bears the economic risk of loss with respect to the Member nonrecourse debt to which such Member nonrecourse deductions are attributable, in accordance with Treasury Regulations Section 1.704-2(i).

(g) Section 754 Adjustments. To the extent an adjustment to the adjusted tax basis of any Company asset pursuant to Code Sections 732, 734(b) or 743(b) is required, pursuant to Treasury Regulations Section 1.704-1(b)(2)(iv)(m), to be taken into account in determining Capital Accounts, the amount of such adjustment to the Capital Accounts shall be treated as an item of gain (if the adjustment increases the basis of the asset) or loss (if the adjustment decreases such basis) and such gain or loss shall be specially allocated to the Members in a manner consistent with the manner in which their Capital Accounts are required to be adjusted pursuant to such Section of the Treasury Regulations.

(h) Curative Allocations. The allocations set forth in this Section 9.2 (the "Regulatory Allocations") are intended to comply with certain requirements of Treasury Regulations Section 1.704-1(b). Notwithstanding any other provision of this Article (other than the Regulatory Allocations), the Regulatory Allocations shall be taken into account in allocating other items of income, gain, loss, and deduction, and credit among the Members so that, to the extent possible, the net amount of such allocations of other items and the Regulatory Allocations to each Member shall be equal to the net amount that would have been allocated to each such Member if the Regulatory Allocations had not occurred.

(i) Tax Allocations: Section 704(c) of the Code. In accordance with Section 704(c) of the Code, income, gain, loss and deduction with respect to any property contributed by any Member to the Company shall, solely for tax purposes, be allocated among the Members so as to take account of any variation between the adjusted basis of such property to the Company for federal income tax purposes and its Book Value, in the same manner as such variations are treated under Section 704(c) of the Code. Any elections or other decisions related to such allocations shall be made by the Managing Member in any manner that reasonably reflects the purpose and intention of the Agreement. Allocations pursuant to this Section 9.2(i) are solely for purposes of federal, state and local taxes and shall not affect, or in any way be taken into account in computing any Member's Capital Account or share of income, gain, loss or deduction pursuant to any other provision of this Agreement.

9.3 Other Allocation Rules.

(a) Net Profits, Net Losses, and all other items of Company income, gain, loss, deduction and credit shall be determined by the Managing Member on a daily, monthly or other basis, using any method permitted under Code Section 706 and the Treasury Regulations.

(b) The Members are aware of the tax consequences of the allocations required under this Article IX and each Member hereby agrees to be bound by the provisions of this Article IX in reporting such Member's share of Company income, gain, loss and deduction for federal income tax purposes.

(c) Solely for purposes of determining a Member's proportionate share of the "excess nonrecourse liabilities" of the Company (within the meaning of Treasury Regulations Section 1.752-3(a)(3)), the Members' interests in Company profits are in proportion to their Percentage Interests.

(d) If the Book Value of any Company Property is adjusted pursuant to Section 8.4(b), subsequent allocations of items of taxable income, gain, loss and deduction with respect to such Company Property shall take account of any variation between the tax basis of such Company Property and its Book Value in the same manner as required under Code Section 704(c).

9.4 Safe Harbor Election. On behalf of the Company, the Managing Member is authorized to elect the "safe harbor" described in the final Treasury Regulations and any other final pronouncements of the Internal Revenue Service that shall apply to any compensatory issuance of Units or other interests in this Company in consideration for the performance of services. Upon the making of such election by the Managing Member on behalf of the Company, the Company and all Members shall comply with the requirements of such safe harbor while the election remains in effect.

ARTICLE X

DISTRIBUTIONS AND OTHER PAYMENTS

10.1 (a) Distributable Cash. Except as otherwise provided in Section 10.1(b) and Section 10.1(c) below, the Company shall distribute its Distributable Cash to the Members quarterly, as follows:

(i) First, to the holders of Class A Units until the holders of Class A Units have received an amount equal to their Unrecovered Capital Contributions; and

(ii) Second, to the Members or holders of Units in proportion to their respective Percentage Interests as they exist on the distribution date.

(b) Tax Distributions. Notwithstanding the distribution provisions of Section 10.1(a) hereof but subject to any HUD rules or regulations, the Company shall distribute out of the Distributable Cash to each of the Members, within One hundred and Twenty (120) days after the end of each Fiscal Year, an amount equal to forty percent (40%) (or such lesser percentage as determined by the Managing Member to be necessary to cover the Members' aggregate tax obligations) of the aggregate Net Profits, if any, allocated to such Member for the most recently ended fiscal year of the Company, but only to the extent that such amount had not already been distributed to the Member under Section 10.1(a) during such Fiscal Year. To the extent paid, such "tax distributions" by the Company shall be applied to the Company's outstanding distribution obligations to the Members under Section 10.1(a).

(c) Liquidating Distributions. Upon liquidation (within the meaning of such term as set forth in Section 1.704-1(b)(2)(ii)(g) of the Treasury Regulations) of the Company or its Membership Interests, or within 30 days of receipt of the proceeds from the sale of substantially all of the assets of the Company, liquidating distributions will be made in the following manner:

(i) First, to the payment and discharge of all of the Company's debts and liabilities to creditors, including without limitation, all fees and expenses due under Section 10.2 hereof;

(ii) Second, to the payment and discharge of all of the Company's debts and liabilities to the Members including, without limitation, the Company's obligation to pay to the Members all outstanding fees and expenses;

(iii) Third, in accordance with Section 10.1(a)(i);

(iv) Fourth, in accordance with Section 10.1(a)(ii); and

(v) Thereafter, the balance, if any, to the Members, in accordance with their positive Capital Account balances, after giving effect to all contributions, distributions, and allocations required or provided in this Agreement for all prior periods;

10.2 Fees and Expenses. Without further approval from the Members, the Managing Member shall be authorized to pay the operating expenses of the Company and to reimburse the Managing Member and the Members for reasonable out of pocket expenses incurred by the Managing Member or the Members, as applicable, for the benefit of the Company, including without limitation formation costs and costs of negotiating the Purchase Agreement and certain other operating agreements and purchase agreements, as may be approved by the Managing Member. The Managing Member shall have the further authority to pay to Members or their Affiliates additional fees for services rendered to the Company on such terms and at such times as shall receive Unanimous Member Approval.

10.3 Amounts Withheld. All amounts withheld as required by the Code or any provision of state or local law with respect to any payment or distribution to the Members shall be treated as amounts distributed to the Members pursuant to this Article X for all purposes under this Agreement. The Managing Member may allocate any such amounts among the Members in any manner that is in accordance with applicable law.

10.4 No Third-Party Beneficiaries. The foregoing priorities of application of Distributable Cash are for the benefit of the Members only and not for the benefit of any third party or creditor of the Company or any Member, and none of the Company, the Managing Member, nor other Members shall be liable or responsible to any third party or creditor of the Company or of the Members for any deviation from such priorities.

ARTICLE XI

BOOKS AND RECORDS

At the Company's expense, the Managing Member shall maintain at the corporate headquarters of the Company at 600 Broadway, Lynbrook, NY or such other place as the Managing Member may designate with consent of a Supermajority. Proper and complete records and books of account in which shall be entered fully and accurately all transactions and other matters relating to the Company's business as are usually entered into records and books of account maintained by persons engaged in businesses of a like character shall be maintained at such Headquarters. The Company books and records shall be kept on the accrual basis, unless a different accounting method is permitted under applicable law and the Managing Member, with approval of a Supermajority elects to employ such method. The books and records shall be open to the reasonable inspection and examination by the Members or their duly authorized representatives during reasonable business hours and each Member shall be permitted at his expense to audit the same. The company shall cooperate in any such audit.

ARTICLE XII

FISCAL YEAR

The fiscal year of the Company shall end on April 30 of each year.

ARTICLE XIII

COMPANY FUNDS

The funds of the Company shall be deposited in such bank account or accounts, or invested in such interest-bearing or non-interest-bearing investments, as shall be designated by the Managing Member. Any such Decision of the Managing Member may be overridden by an affirmative vote of a Supermajority. All withdrawals from any such bank accounts or investments shall be made by the Managing Member or by agents duly appointed or authorized by the Managing Member. Company funds shall be separately identifiable from and not commingled with those of any other Person.

ARTICLE XIV

RIGHT AND DUTIES OF MEMBERS

14.1 Limited Role in Management. The Members shall not participate in the management or control of the Company's business, transact any business for the Company or have the power to act for or bind the Company, except to the extent expressly set forth in the Articles or in this Agreement, said powers being vested solely and exclusively in the Managing Member. Notwithstanding the foregoing, Managing Member shall obtain bids, and Members shall be permitted to obtain bids as well, for any contract which is not terminable upon 90 day written notice or which has the aggregate value of more than $60,000 per annum. The Managing Member shall always accept the lowest competent bidder. Should such vendor not be the least expensive, Managing Member shall so advise the Members and obtain approval of a supermajority prior to utilizing the same. In no event shall any Member or the Managing

Member receive any kickback or undisclosed benefit from any Vendor or engage in any unlawful act.

14.2 Liability for Company Debt. Unless a Member otherwise agrees in writing, no Member will be personally liable for any debts or losses of the Company, except as otherwise required by law. Notwithstanding the foregoing, each Class A Member agrees to guarantee any note and mortgage of the Company up to his percentage of interest.

14.3 Election of Managing Members and Appointment of CEO. The initial Managing Member shall be Ephram Lahasky("Initial Managing Member"). If the Initial Managing Member shall dissolve or resign as Managing Member, then the Members shall select a new Managing Member as set forth in Articles XV and XVI hereof.

14.4 Priority and Return of Capital. Except as may be expressly provided in this Agreement, no Member shall have priority over any other Member, either as to the return of Capital Contributions or as to Net Profits, Net Losses or distributions; provided that this Section shall not apply to Rescue Loans or other loans (as distinguished from Capital Contributions) which a Member has made to the Company nor to the fees described or otherwise approved as set forth in Section 10.2 hereof.

14.5 Liability of a Member to the Company. A Member holds as trustee for the Company money or other property wrongfully or erroneously paid or conveyed to such Member.

14.6 No Preemptive Rights. Except as otherwise provided in Section 20.1 hereof, no Member shall have any preemptive or preferential right, including any such right with respect to (a) issuance or sale of Membership Interests, whether unissued or hereafter created; (b) issuance of any obligations, evidences of indebtedness or other securities of the Company convertible into or exchangeable for, or carrying or accompanied by any rights to receive, purchase or subscribe to, any such unissued Units or other Membership Interest; (c) any warrant or option for the purchase of, any of the foregoing securities; or (d) issuance or sale of any other securities that may be issued or sold by the Company.

14.7 Resignation/Withdrawal. A Member may voluntarily withdraw or resign from the Company only with the prior written consent of the Managing Member and a Supermajority Interest of the other non-withdrawing Members, if any. A Member must resign if he is excluded or otherwise prohibited by any governmental agency from owning and/or operating Nursing home assets as the case may be. Such Member shall be entitled to receive from the Company for his, her or its Membership Interest an amount equal to the positive balance of the Member's Capital Account as of the effective date of the withdrawal or resignation within nine (9) months following the effective date of the withdrawal or resignation. A resigning or withdrawing Member shall be immediately required to pay any sums owed to the Company by such resigning Member (including, without limitation, any unpaid additional Capital Contributions duly requested as provided herein). The resignation or withdrawal of any Member from the Company without the prior written consent of the Managing Member and a Majority Interest of the other Members shall constitute a wrongful dissociation. Any Member who wrongfully dissociates from the Company shall not be entitled to receive any payment for his, her or its Membership Interest from the Company prior to the dissolution and termination of the Company and shall be

liable to the Company and/or other Members for any damages or expenses directly or indirectly caused by such resignation or withdrawal, which liability is in addition to any other obligation of that Member to the Company or to the other Members.

14.8 Independent Activities. Any of the Members may engage in or possess an interest in other business ventures of every nature and description, independently or with others, including, but not limited to, the ownership, leasing, or operations of skilled nursing facilities or senior living facilities, and neither the Company nor any of the other Members shall have any right by virtue of this Agreement in and to such independent ventures or to the income, profits or proceeds derived therefrom. Notwithstanding the foregoing, no Member may hire or cause or encourage others to hire persons employed by the Company or who have been employed by the Company anytime within 12 months of the hire date and no Member shall compete with the Facility or assist any other in competing with the Company in its market as defined by drawing residents from the same or overlapping feeder sources without Unanimous Approval of the Members.

14.9 Transactions with Affiliates. Agreement or transaction between the Company and any Member, Managing Member or his, her or its Affiliates shall be void or voidable solely by reason of such relationship unless such relationship is disclosed and the Agreement or transaction is approved by Managing Member and ratified by a Supermajority. The execution of any such agreement or the entering into a consummation of such transaction by the Company shall not subject the participating Member, Managing Member or any of his, hers or its Affiliates or their officers, directors, Managing Member s, members or stockholders to liability to the Company or any Member for breach of fiduciary duty if (i) such agreement or transaction is on terms, taken as a whole, that are better than those available in the marketplace or (ii) a Supermajority approves or ratify such agreement or transaction.

ARTICLE XV

MEETINGS OF MEMBERS

15.1 Meetings. Meetings of the Members, for any purpose or purposes, unless otherwise prescribed by the Act, may be called by the Managing Member or any Class A Member.

15.2 Place of Meetings. The Managing Member or any Class A Member may designate any place, within or without the State of New York as the place of meeting for any meeting of the Members. If no designation is made, or if a special meeting be otherwise called, the place of meeting shall be at the principal place of business of the Company. Telephonic participation shall be permitted.

15.3 Quorum. The Members holding a Majority Interest, represented in person or by proxy, shall constitute a quorum at any meeting of Members, but only those representing a Supermajority may take such action requiring a vote of a Supermajority and those representing a Unanimous Interest may take such action requiring a vote of a Unanimous Interest. In the absence of a quorum at any such meeting, a majority of the Units so represented may adjourn the meeting from time to time for a period not to exceed sixty (60) days without notice. However, if

the adjournment is for more than sixty (60) days, or if after the adjournment a new record date is fixed for the adjourned meeting, a notice of the adjourned meeting shall be given to each Member of record entitled to vote at the meeting. At such adjourned meeting at which a quorum shall be present or represented, any business may be transacted which might have been transacted at the meeting as originally noticed. The Members present at a duly organized meeting may continue to transact business until adjournment, notwithstanding the withdrawal during such meeting of Members holding that number of Units whose absence would cause less than a quorum to be represented.

15.4 Manner of Acting. If a quorum is present, the affirmative vote of Members holding a Majority Interest shall be the act of the Members, unless the vote of a greater or lesser proportion or number is otherwise required by the Act, by the Articles, or by this Agreement.

15.5 Action by Members Without a Meeting. Action required or permitted to be taken at a meeting of Members may be taken without a meeting if the action is evidenced by one or more written consents describing the action taken, provided such consent is delivered to each Member entitled to vote and that signed consents from voting Members holding at least a Majority Interest are delivered to the Managing Member of the Company for inclusion in the minutes or for filing with the Company records. Action taken under this Section is effective when the Members holding at least a Majority Interest have signed the consent, unless the consent specifies a different effective date. The record date for determining Members entitled to take action without a meeting shall be the date the first Member signs a written consent.

ARTICLE XVI

POWERS, RIGHTS AND DUTIES OF THE Managing Member

16.1 Authority of Managing Member. Subject to the limitations herein, the Chief Executive shall be charged with responsibility for all day to day functions of the business of the Company with oversight from the Managing Member which shall have authority to manage the operations and affairs of the Company and to make all decisions regarding the business of the Company. Without limiting the generality of the foregoing, the Managing Member shall have exclusive authority to establish such business strategies, accounting procedures and other practices and to make such business decisions as the Managing Member, in his, her or its sole discretion, subject to the Terms and Conditions of this Operating Agreement, deems advisable for the operation of the Company. In addition, it is understood and agreed that the Managing Member shall have all of the rights and powers of a Managing Member as provided in the Act and as otherwise provided by law, and unless set forth herein to the contrary any action taken by the Managing Member shall constitute the act of and serve to bind the Company. In dealing with the Managing Member acting on behalf of the Company, no person shall be required to inquire into the authority of the Managing Member to bind the Company. Persons dealing with the Company are entitled to rely conclusively on the power and authority of the Managing Member as set forth in this Agreement.

16.2 Identity and Qualifications of the Managing Member.

(a) The Managing Member of the Company shall be Ephram Lahasky, until such time as his resignation or removal as Managing Member. Upon such dissolution, resignation or removal of Ephram Lahasky, as Managing Member, then the Managing Member shall be elected by a Supermajority Interest.

16.3 Certain Member Rights. The Managing Member must obtain the consent of a Supermajority Interest before he, she or it may take any of the following actions:

(a) purchase corporate equity or debt securities, partnership interests, membership or economic interests in limited liability companies, or other investments, with a value of more than $50,000 in the aggregate;

(b) acquire real property, with a purchase price of more than $50,000 in the aggregate,

(c) acquire personal property, with a purchase price of more than $100,000 in the aggregate per facility owned directly or indirectly by the Company;

(d) borrow money for and in the name of the Company from banks, other lending institutions, the Members, or Affiliates of the Members, or guarantee indebtedness of an Affiliate, in an amount of more than $50,000 in the aggregate;

(e) invest any Company funds temporarily (by way of example but not limitation) in time deposits, short-term governmental obligations, commercial paper or other investments, in an amount of more than $100,000 in the aggregate;

(f) sell or otherwise dispose of all or substantially all of the Company's Property or any material portion thereof;

(g) sell or refinance any of the properties held by the Company or its direct or indirect subsidiary entities, provided, however, that no Member shall unreasonably withhold his, her or its consent hereunder provided that the net proceeds of such sale or refinance are used to pay the Class A Member all of its Unrecovered Capital Contributions;

(h) make capital or other expenditures in an amount greater than $50,000 in the aggregate (only to the extent in excess of amounts eligible for reimbursement by HUD);

(i) enter into any agreement for any of the foregoing;

(j) approve or permit the Company's direct or indirect subsidiary entities to take any of the foregoing actions.

Unless authorized to do so by this Agreement or by the Managing Member of the Company, no attorney-in-fact, employee, or agent of the Company shall have any power or authority to bind the Company in any way, to pledge its credit, or to render it liable pecuniarily for any purpose. No Member shall have any power or authority to bind the Company unless the Member has been authorized by the Managing Member to act as an agent of the Company in accordance with the

previous sentence. However, the Managing Member may act by a duly authorized agent or attorney-in-fact.

16.4 Managing Members Have No Exclusive Duty To Company. The Managing Member shall not be required to manage the Company as the Managing Member's sole and exclusive function and may have other business interests and may engage in other activities in addition to those relating to the Company. Neither the Company nor any Member shall have any right, by virtue of this Agreement, to share or participate in such other investments or activities of the Managing Member or in the income or proceeds derived therefrom. Notwithstanding the foregoing, neither Managing Member, not any of its principals shall compete with the Company, hire or assist or encourage others to hire any employee of the Company or former employee to the extent they have been employed by the Company within the prior twelve (12) month period without the consent of a Supermajority. Managing Member also owes a duty of loyalty to the Company and shall make all decisions based upon reasonable business judgment which shall be driven by desire to provide quality and cost efficient patient care and to maximize revenue opportunities.

16.5 Indemnity of the Managing Member and Members. The Managing Member and the Members shall be indemnified by the Company under the following circumstances and in the manner and to the extent indicated:

(a) In any threatened, pending or completed action, suit or proceeding to which a Managing Member or Member, as applicable, was or is a party or is threatened to be made a party by reason of the fact that he, she or it is or was a Managing Member or Member of the Company (other than an action by or in the right of the Company) involving an alleged cause of action for damages arising from the performance of his, her or its activities on behalf of the Company, the Company shall indemnify such Managing Member or Member, as applicable, against expenses, including reasonable attorney's fees, judgments and amounts paid in settlement, actually and reasonably incurred by him in connection with such action, suit or proceeding if the Managing Member or Member, as applicable, acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the Company (which determination shall be made as provided in the Act) and provided that his, her or its conduct has not been found by a nonappealable court judgment, order, decree or decision to constitute gross negligence, willful or wanton misconduct, or a breach of his, her or its fiduciary obligations to the Members. The termination of any action, suit or proceeding by judgment, order, settlement, or plea of nolo contendere shall not, of itself, create a presumption that the Managing Member or Member, as applicable, did not act in good faith and in a manner which he reasonably believed to be in or not opposed to the best interests of the Company.

(b) To the extent the Managing Member has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in paragraph (a) above, or in defense of any claim, issue or matter therein, the Company shall indemnify the Managing Member against the expenses, including attorney's fees, actually and reasonably incurred by him in connection therewith.

(c) The indemnification set forth in this paragraph shall in no event cause the Members to incur any liability beyond their total Capital Contributions plus their share of any

undistributed Net Profits of the Company, nor shall it result in any liability of the Members to any third party. Likewise, under no circumstances shall any member or Managing Member be indemnified for any unlawful act or civil penalty paid as a result of the commission of an act which if proven beyond a reasonable doubt would have criminal penalties.

16.6 Resignation. A Managing Member of the Company may resign at any time by giving written notice to the Members of the Company. The resignation of a Managing Member shall take effect upon receipt of notice thereof or at such later time as shall be specified in such notice; and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective. The resignation of a Managing Member who is also a Member shall not affect the Managing Member's rights as a Member and shall not constitute a withdrawal of a Member except that such Member shall be required to make capital contributions as if he were a Class A Member from Company inception.

16.7 Removal. Any Managing Member may be removed, with or without cause, by the affirmative vote or written consent of all Members. The removal of a Managing Member who is also a Member shall not affect the Managing Member's rights as a Member and shall not constitute a withdrawal of a Member.

16.8 Vacancies. If there is a vacancy in the office of Managing Member, it may be filled by a Supermajority. A Managing Member elected to fill a vacancy shall be elected for the unexpired term of his, her or its predecessor in office and shall hold office until his, her or its successor shall be elected and shall qualify, or until his, her or its earlier death, resignation or removal.

16.9 Business Transactions of the Managing Member with the Company. Except as otherwise stated in this Agreement or required under the Act, the Managing Member may lend money to, act as surety, guarantor or endorser for, guarantee or assume one or more obligations of, provide collateral for, and transact other business with, the Company and (subject to applicable law) shall have the same rights and obligations with respect to any such matter as a Person who is not a Managing Member, so long as any such transaction does not violate this Agreement or is not commercially unreasonable and is entered into in the good faith belief the foregoing is for the benefit of the Company. The Managing Member shall not be required to obtain an independent fairness opinion and may rely on its business judgment in determining any consideration received by Managing Member or its Affiliates.

ARTICLE XVII

TRANSFER OF MEMBERSHIP INTEREST

17.1 Transfer of Membership Interest. A Member shall not Transfer all or any part of his, her or its Units or Membership Interest without: (a) the prior consent of a Supermajority, and (b) full compliance with all provisions of Article XVII of this Agreement.

17.2 Restrictions on Transfer of Interests.

(a) Voluntary Transfer. If a Member desires to Transfer (in such capacity, a "Transferor") all or any portion of the Units it owns (the "Transferred Interests"), and has

received a bona fide written offer (the "Offer") to Transfer the Transferred Interests to a third party which is not an Affiliate of such Transferor (the "Transferee"), the Transferor shall deliver a written notice (a "Transfer Notice") to the Managing Member and the other Members of the Company (in such capacity, the "Non-Selling Members") of its desire to Transfer the Transferred Interests. The Transfer Notice shall state the number of Units the Transferor desires to Transfer, as well as the purchase price for the Transferred Interests (disclosed on both an aggregate and per Unit basis) and any terms and conditions of payment, all of which shall correspond to the price, terms and conditions set forth in the Offer. The Transfer Notice also shall include a true and complete copy of the Offer. For sixty (60) days following the Managing Member's receipt of the Transfer Notice (the "Company Option Period"), the Company shall have the exclusive option to purchase one or more of the Transferred Interests for the price per Unit and upon the terms and conditions of payment set forth in the Transfer Notice. If the Company does not exercise its option to purchase all, of such Transferred Interests during the Company Option Period, then for a period of sixty (60) days after the expiration of the Company Option Period (the "Non-Selling Members Option Period"), each Non-Selling Member shall collectively have the option to purchase up to its pro rata share of all of the Transferred Interests that the Company did not elect to purchase at the price per Unit and upon the terms and conditions set forth in the Transfer Notice. If the Company and the Non-Selling Members do not collectively exercise their option to purchase all, but not less than all, of such Transferred Interests by the end of the Non-Selling Members Option Period, then, at any time within one hundred fifty (150) days of the expiration of the Non-Selling Members Option Period, the Transferor may Transfer the Transferred Interests to the Transferee but only at a price that is at least equal to the price, and upon the other terms and conditions, set forth in the Transfer Notice and the Offer.

(b) Involuntary Transfers. In the event of the death, incompetency, bankruptcy; dissolution of a Member or in the event that such person is ineligible by governmental decree or action to own the assets of the Company (in such capacity, a "Withdrawing Member"), (i) for a period of ninety (90) days after the Managing Member receives actual notice thereof, the Company shall have the option to purchase all, or any portion, of the Units and Membership Interests of the Withdrawing Member (the "Withdrawing Member's Interests"), for the price and upon the terms set forth in Section 17.2(e) below. If the Company does not exercise its option to purchase all of the Withdrawing Member's Interest, for a period ending thirty (30) days after the close of the Company's ninety (90) day option period, the non-Withdrawing Members (the "Non-Withdrawing Members") shall have an option to purchase all, but not less than all, of such Withdrawing Member's Interest not purchased by the Company at the price set forth in Section 17.2(e) below. If the Company and the Non-Withdrawing Members do not exercise their respective options in this Section 17.2(b), then the Withdrawing Member's Interests shall remain fully subject to all terms and conditions of this Agreement in the hands of the Withdrawing Member and all of its heirs, successors in interest and legal representatives.

(c) Transfers of Interests in Member. A Member that is not a natural person may not cause or permit an ownership interest, direct or indirect, in itself to be disposed of such that, after the disposition: (i) the Company would be considered to have terminated within the meaning of Code Section 708; or (ii) without the prior written consent of the a Supermajority, such Member (the "Breaching Member") shall cease to be controlled by substantially the same Persons who control it as of the date of the Breaching Member's admission to the Company. For

a period of one hundred twenty (120) days after the Company receives actual notice of any Member's breach of the provisions of clause (ii) of the immediately preceding sentence, the Company shall have the exclusive option to buy, and upon exercise of that option the Breaching Member shall sell, all of the Breaching Member's Units and Membership Interest, at the price determined in accordance with Section 17.2(e). The Breaching Member shall deliver documents satisfactory to the Company conveying its Interest free and clear of all liens, claims and encumbrances, any of which may be paid out of the purchase price, with the remainder, if any, paid to the Breaching Member. If the purchase price is insufficient to satisfy any such liens, the Breaching Member shall discharge the balance.

(d) Exercise of Options. The Company, the Non-Selling Members or the Non-Withdrawing Members, as the case may be, who exercise any option granted by this Section 17.2 or by Sections 17.5 or 17.6 shall do so by giving written notice (an "Exercise Notice") of the exercise of their respective options within the time periods provided in such Section to the Transferor or a Withdrawing Member or a Breaching Member, as the case may be. Such notice shall be effective upon the date provided in Section 22.1 hereof.

(e) Purchase Price and Terms.

(i) Purchase Price. If the Company or the Non-Withdrawing Members exercise their respective options in Section 17.2 (in such capacity, the "Optionor"), the purchase price which the Optionor shall pay for the Interest of the Withdrawing Member or the Breaching Member (in either case, referred to herein as the "Transferring Member") following the exercise of an option to purchase under Section 17.2(b) or Section 17.2(c) shall be an amount equal to the value of the Transferring Member's Interest as determined in this Section 17.2(e). The value of the Transferring Member's Interests shall be an amount that is mutually agreed upon by the Optionor and the Transferring Member. If they cannot agree within ten (10) days after the date of the final Exercise Notice, the purchase price shall be the amount which the Transferring Member would receive if all the Company's properties and assets were sold at their appraised fair market value and the proceeds were applied in accordance with Section 10.1(c) hereof, provided, however, that the assets of the Company shall be deemed to exclude the accounts of the Member which will no longer be managed by the Company following the purchase of such Units. An independent appraiser (a "Qualified Appraiser") experienced in conducting appraisals of assets similar to the Company property shall conduct an appraisal of all of the Company property to determine its fair market value (the "First Appraisal"). The Optionor shall select a Qualified Appraiser to perform the First Appraisal and shall assume the cost of the First Appraisal. If, within five (5) days after receipt of the First Appraisal, the Transferring Member disputes the value determined by the First Appraisal, the Transferring Member may obtain, at his, her or its own cost, a second appraisal (the "Second Appraisal") of the fair market value of the Company property by a Qualified Appraiser of its choice. If the parties agree, the Second Appraisal shall be used to determine the value of the Company property. If the two appraisals are performed and the parties cannot agree within ten (10) days which of the appraisals accurately reflects the value of the Company property, then the parties shall have the option of either (A) obtaining, a third appraisal (the "Third Appraisal") to be performed by a Qualified Appraiser mutually agreeable to, and with fees paid one half by

each of, the Transferring Member and the Optionor; or (B) submitting the matter to arbitration in accordance with Section 22.5.

(ii) Payment of Purchase Price and Closing. The closing of any sale and purchase of the Transferring Member's Interest in the Company shall be within thirty (30) days from the later of (1) the date of the final Exercise Notice; or (2) delivery of the final appraisal performed pursuant to Section 17.2(e)(i). The Optionor shall pay the purchase price in four equal installments, with the first installment payable at the closing and the next three installments payable on the first, second and third year anniversaries of such closing. At the Transferring Member's option, the Optionor will deliver a promissory note for the balance of the purchase price at the closing. No interest will accrue on the unpaid balance of the purchase price. The Transferring Member shall deliver documents satisfactory to the Optionor conveying its Units and Membership Interest free and clear of all liens, claims and encumbrances, any of which may be paid out of the purchase price, with the remainder, if any, paid to the Transferring Member. If the purchase price is insufficient to satisfy any such liens, the Transferring Member shall discharge the balance.

(f) Requirements for Transfer. Notwithstanding anything to the contrary in this Agreement, the Transfer of any Units or part thereof shall be subject to any restrictions on transferability required by law (including the Securities Act of 1933, any state securities or "Blue Sky" law, and the rules promulgated thereunder). Furthermore, no Transfer shall be effective unless and until all of the following requirements are satisfied: (i) the transferee is a citizen and resident of the United States, and otherwise not a tax-exempt entity under Section 168(h) of the Code; (ii) the transferor delivers to the Managing Member an opinion of counsel, in form and substance satisfactory to counsel designated by the Managing Member that neither the Transfer nor any offering in connection therewith violates any provision of any federal or state securities law or rules promulgated thereunder; (iii) the transferee executes a statement that he is acquiring such Units or such part thereof for his, her or its own account for investment and not with a view to distribution, fractionalization or resale thereof; (iv) the written acceptance and adoption by the transferee of the provisions of this Agreement including a representation and warranty that the representations and warranties in Section 17.4 are true and correct with respect to the transferee; (v) the transferee's payment of a transfer fee sufficient to cover all expenses of the Company connected with such Transfer; and (vi) the Transfer would not result in the termination of the Company (within the meaning of Section 708(b) of the Code) or the termination of its status as a partnership under the Code. The Transfer by a Member of all or part of his, her or its Units shall become effective on the day (the "Transfer Date") in which all of the requirements of this Section 17.2 have been met; provided, however, that the Managing Member may elect to waive the delivery of the opinion of counsel and the payment of a transfer fee in his, her or its sole discretion. All distributions prior to the Transfer Date shall be made to the transferor and all distributions made thereafter shall be made to the transferee.

(g) HUD Consent. The parties acknowledge that certain facilities to be owned by its direct or indirect subsidiaries and affiliates may obtain a HUD-insured first mortgage loans from a commercial lender (the "HUD Lender"). To the extent the foregoing occurs, any Transfers or changes in the ownership interests of the Company with respect to the HUD

Facilities is expressly conditioned upon approval by HUD and the HUD Lender ("HUD Consents") and no such Transfer shall be effective prior to receipt of the HUD Consents.

(h) Operating Rules. If the Company and more than one Member constitute the "Optionor" for purposes of Section 17.2(e), then a Supermajority will determine any deadlock or other dispute among them concerning a decision required to be made hereunder by the Optionor. If more than one Member exercises its right to make a purchase of an Interest under this Section 17.2 with respect to any single Transfer subject thereto, then each exercising Member shall participate in the purchase of a proportionate part of such Interest in the same proportion as the number of Units then owned by such exercising Members bears to the number of Units then owned by all such exercising Members.

17.3 Substituted Members. Following a Transfer that complies with the requirements of Section 17.2 and the other provisions hereof, to the extent such requirements have not been waived by the Managing Member and a Supermajority, the assignee or transferee of all or part of a Member's Units may be admitted to the Company as a Member in the place and stead of, or together with, as the case may be, the Member who has assigned or transferred all or part of his, her or its Units, but only upon satisfaction of all of the following conditions:

(a) A duly executed and acknowledge written instrument of transfer approved by the Managing Member setting forth (i) the intention of the transferee to be admitted as a Member; (ii) the notice address of the transferee; and (iii) the number of Units transferred by the transferor to the transferee;

(b) The transferor and transferee execute and acknowledge all instruments and provide such other evidence as the Managing Member may reasonably deem necessary or desirable to effect such admission; and

(c) The admission is approved by a Supermajority, which consent may be granted or withheld in the sole discretion of the Supermajority.

Upon satisfaction of all of the foregoing conditions and the admission of the assignee as a Member, the Managing Member shall be authorized to amend this Agreement and any Exhibits thereto to reflect such admission. Alternatively, if any of the conditions above are not satisfied and the transferee of a Membership Interest is not admitted as a Member, the Transferee shall be considered the holder of an Economic Interest, entitled to receive the allocations and distributions attributable to the Transferred Interest, but shall not be entitled to inspect the Company's books and records, receive an accounting of Company financial affairs, exercise voting rights, if any, of the transferor Member, or otherwise take part in the Company's business or exercise the rights of a Member under this Agreement.

17.4 Drag Along. Notwithstanding anything in this Article XVII or otherwise in this Agreement to the contrary, if a Majority Interest desires to sell its or their Units and receives a "bona fide offer" from a third party to acquire all, but not less than all, of the outstanding Units of the Company, the Majority Interest shall have the right to sell all, but not less than all, of its Units and to require any remaining Members to sell all of their Units to the proposed transferee on the same terms and conditions stated in the offer provided, however, that if the remaining

Members are Class A Members, they shall have the right to receive accrued but unpaid Preferred Return with respect to their Units in addition to the purchase price proposed in the offer as a condition to the exercise of the rights of the Majority Interest contained in this Section 17.4. The Majority Interest shall deliver to the Company and each remaining Member a written notice stating all of the terms and conditions of the offer together with a copy of the offer or letter of intent and that the Majority Interest wishes to exercise its right under this Section 17.4. The Majority Interest may exercise its right under this Section 17.4 without complying with Section 17.2 of this Agreement, and no Member shall have a Right of First Refusal otherwise provided for in the Article XVII or elsewhere in this Agreement. Upon exercise of right under this Section 17.4, each Member shall take all steps necessary and sign all documents requested by the Majority Interest to cause the sale of each such Member's Units to be consummated as required pursuant to the terms and conditions of the bona fide offer and this Section 17.4.

ARTICLE XVIII

DISSOLUTION OF THE COMPANY

18.1 Events of Dissolution. The happening of any of the following events shall cause an immediate dissolution of the Company:

(a) Determination of the Unanimous Member Approval;

(b) entry of a decree of judicial dissolution; or

(c) administrative dissolution BY LAW.

18.2 Winding Up. In the event of the dissolution of the Company for any reason, the Managing Member or, in the event that there is no Managing Member, a liquidator or a liquidating committee selected by a Supermajority, shall wind up the affairs of the Company. The Members shall continue to share the Net Profits and Net Losses during the period of liquidation in the same proportion as before the dissolution. The Managing Member (or such liquidator or liquidating committee) subject to approval of a Supermajority, based upon the plan set forth by the Managing Member, shall have full right and, discretion granted to him to determine the time, manner and terms of any sale or sales of Company assets pursuant to such liquidation.

18.3 Distribution of Liquidation Proceeds. Following the payment of all debts and liabilities of the Company and all expenses of liquidation and subject to the right of the Managing Member (or such liquidator or liquidating committee) to set up such Reserves as reasonably necessary for any contingent or unforeseen liabilities or obligations of the Company, the proceeds of the liquidation and any other funds of the Company shall be distributed in accordance with Section 10.1(c) hereof.

18.4 Limitation on Distribution Rights Upon Dissolution. Each Member shall look solely to the assets of the Company for all distributions with respect to the Company and for the return of any unpaid portion of his, her or its Capital Contribution and shall have no recourse

therefor against any other Member. No Member shall have any right to demand or receive property other than cash upon dissolution and termination of the Company or, except with respect to the Preferred Return, to demand the return of any part of the Capital Contributions prior to dissolution and termination of the Company.

18.5 Dissolution Documents. Upon the dissolution and the commencement of winding up of the Company, the Managing Member shall have the authority to execute and record Articles of Dissolution of the Company as well as any and all other documents required to effectuate the dissolution and termination of the Company.

ARTICLE XIX

AMENDMENT OF AGREEMENT AND ARTICLES OF ORGANIZATION

Except as otherwise provided in the Act, this Agreement or the Articles may be amended upon the affirmative vote of a Supermajority Interest and with approval of the Managing Member.

ARTICLE XX

ISSUANCE OF NEW UNITS AND ADMISSION OF NEW MEMBERS

20.1 Approval Requirements. The issuance of new Units of any class and the terms and conditions of any such issuance must be approved by a Supermajority Interest. The holders of any newly issued Units (other than the existing Members) shall be admitted as a Member upon such terms and conditions as the Managing Member and a Supermajority Interest may determine, consistent with this Agreement, the Articles and any applicable provision of law.

20.2 Allocations to New Members. No new Member shall be entitled to any retroactive allocation of any item of income, gain, loss, deduction or credit of the Company.

ARTICLE XXI

CERTAIN REPRESENTATIONS OF CLASS A; HUD PROVISIONS

21.1 Class A Member Representations. The Class A Members, for itself and for its direct and indirect equity owners, members, partners, shareholders, director hereby represents and warrants to the Company:

(a) It has reviewed such financial information, including without limitation those relating to the proposed acquisition and books and records of the Company as it deems

necessary or appropriate, and has had the opportunity to ask any questions about the Company and the proposed acquisition to its complete satisfaction.

(b) It is an "accredited investor" within the meaning of Regulation D under the 1933 Act; has knowledge and experience in financial and business matters such that it is capable of evaluating the merits and risks of owning the Membership Interest or its Interest. It is holding its Units for its own account, for investment purposes only and not with a view to, and with no present intention of, selling or distributing the same.

(c) It understands the risks associated with investment in the Company and can bear the risk of losing its whole investment. It understands that health care facilities are highly regulated and subject to regulatory reform.

(d) It understands that the Company is relying on third party advisors in the conduct of due diligence with respect to its investments and has not made independent evaluation. It is not relying on any express or implied representations or warranties from the Members, Managing Member or any of their respective Affiliates.

21.2 Certain HUD Requirements. For such period of time as the Company or any of its direct or indirect subsidiary entities is seeking approval or is approved as a HUD-mortgagee or correspondent, then the following provisions shall apply:

(a) the Managing Member or any such representative selected by a Supermajority shall have exclusive authority to deal with HUD;

(b) prior to any change in the Managing Member or the Members, the Company shall notify HUD to the extent a HUD loan is then in existence of the change and the new Managing Member shall satisfy all of the requirements of this Agreement and of HUD;

(c) the Managing Member shall ensure that all employees and officers of the Company meet all requirements of HUD (including, without limitation, the requirements set forth in HUD Mortgagee Approval Handbook 4060.1 REV-1, as revised from time to time); and

(d) the Managing Member shall report all changes in the business of the Company as may be required by the rules and regulations of HUD to be reported from time to time.

ARTICLE XXII

MISCELLANEOUS

22.1 Notices. All notices and demands required or permitted under this Agreement shall be in writing and may be sent by overnight courier or personal delivery, if to the Company, in care of the Managing Member at the Company's principal place of business, and if to any Member, to the Member at the Member's address as shown in this Agreement or as otherwise provided from time to time in the records of the Company. Any Member may specify a different address by notifying the Managing Member in writing of such different address. Such notices

addressed as provided herein shall be deemed given the day after deposit with an overnight courier, or when delivered in person, as the case may be.

22.2 Entire Agreement. This Agreement constitutes the entire agreement between the parties relating to the subject matter hereof. It supersedes and overrides any prior agreement or understandings, whether oral or written, between any or all of the parties hereto relating to the subject matter hereof, including without limitation, the terms of the issuance of Units in the Company. This Agreement may not be modified or amended in any manner other than as set forth herein.

22.3 Tax Matters Partner Ephram Lahasky is designated the "Tax Matters Partner" (as defined in section 6231 of the Code), and is authorized and required to represent the Company (at the Company's expense) in connection with all examinations of the Company's affairs by tax authorities, including, without limitation, administrative and judicial proceedings, and to expend Company funds for professional services and costs associated therewith. The Members agree to cooperate with each other and to do or refrain from doing any and all things reasonably required to conduct such proceedings. In particular, and not by way of limitation, the Tax Matters Partner is authorized to file on behalf of the Company any "safe harbor election" authorized by the Treasury Regulations with regard to the valuation of compensatory transfers of interests in the Company.

22.4 Governing Law. This Agreement and the rights of the parties hereunder shall be governed by and interpreted in accordance with the laws of the State of Pensylvania.

22.5 Dispute Resolution. The Members, Managing Member and the Company hereby irrevocably agree to submit any dispute to Arbitration of their choosing which may include a Jewish Rabbinical Court should both parties agree. Notwithstanding the foregoing, should the parties not otherwise agree, such arbitration shall be before a single arbitrator for the American Arbitration Association in New York City. Such Arbitration shall be binding.

22.6 Successors and Assigns. Except as herein otherwise specifically provided, this Agreement shall be binding upon and inure to the benefit of the parties and their legal representatives, heirs, administrators, executors, successors and permitted assigns.

22.7 Captions. Captions contained in this Agreement are inserted only as a matter of convenience and in no way define, limit or extend the scope or intent of this Agreement or any provision thereof.

22.8 Severability. If any provision of this Agreement, or the application of such provision to any person or circumstances shall be held invalid, the remainder of this Agreement, or the application of such provision to persons or circumstances other than those to which it is held invalid, shall not be affected hereby.

22.9 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

22.10 Number and Gender. Whenever the singular number is used in this Agreement and when required by the context, the name shall include the plural, and the masculine gender shall include the feminine and neuter genders.

22.11 Waiver of Partition. To the extent permitted by law, each of the Members irrevocably waives, during the term of the Company, and during the period of its liquidation following dissolution, any right that he may have to maintain any action for partition with respect to the assets of the Company.

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EXHIBIT A

Units of Members

Names of Members Class A	**Units/Percentage Interests**
David Gast	25%
Joshua Farkovits	37.5
Ephram Lahasky	37.5
TOTAL	**100%**

IN WITNESS WHEREOF, the Members have executed this Agreement as of the date first hereinabove set forth.

CLASS A MEMBERS:

By: _____
Name: Ephraim Zolay

By: _____
Name: David Gaist

By: _____
Name:

By: _____
Name: Yoik Furkovits

EXHIBIT 7

The PrivateBank

BUSINESS ENTITY ACCOUNT SIGNATURE CARD

DATE 12/29/2014	Financial Institution Branch Address 120 South LaSalle St Chicago, IL 60602 Opened By: Eugenia Spina

ACCOUNT INFORMATION
TITLE OF ACCOUNT Telegraph Realty, LLC
ACCOUNT NUMBER [redacted]3849
ACCOUNT T.I.N. [redacted]

600 Broadway
Lynbrook NY 11563-3980

PRODUCT NAME Business Checking ☐ Check box if the Account has a Beneficial Owner that is not the Entity

BUSINESS ENTITY INFORMATION (the "Entity")
Business Name and Address
Telegraph Realty, LLC

Assumed Name if D/B/A

600 Broadway
Lynbrook NY 11563-3980

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION
Under penalties of perjury, I certify that:
1. The number shown on this form is the correct taxpayer identification number for the Entity, (or I am waiting for a number to be issued to me), and
2. The Entity is not subject to backup withholding because: (a) it is exempt from backup withholding, or (b) it has not been notified by the Internal Revenue Service (IRS) that it is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified it that it is no longer subject to backup withholding, and
3. The Entity is a U.S. person.
4. The Entity is exempt from FATCA reporting.

You must cross out item 2 above if the Entity has been notified by the IRS that it is currently subject to backup withholding because it failed to report all interest and dividends on its tax return.

12-29-14
SIGNATURE Efram Mordy Lahesky DATE

☐ See separate W-9 Document

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT. To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.
What this means for you: When you open an account, we will ask you for your name, address, date of birth, and other information that will allow us to identify you and the Entity. We may also ask to see your driver's license or other identifying documents.

ACKNOWLEDGMENT. The Entity agrees to be bound by the rules and conditions of The PrivateBank and Trust Company ("Bank") that govern this account, as they may be amended, including the Business Deposit Account Agreement and Disclosure ("Agreement and Disclosure"). By signing this document, I/We acknowledge on behalf of the Entity that the Agreement and Disclosure has been received. I/We certify that all of the information printed on this signature card and that I/We provided to the Bank is true and accurate, including, without limitation, the names and titles of each of the individuals who have signed below. I/We agree that the Bank has the right to charge this account for any liabilities owed to the Bank by the Entity. All signers are acting on behalf of the Entity.

Any one signature required for Account actions. If this Signature Card relates to a Certificate of Deposit, the individuals that execute below and, if applicable, the attached addendum, shall be authorized to transact business under any account for renewals of such Certificate of Deposit.

☒ Check box if the Entity desires that the individuals that execute below, and if applicable, the attached addendum, be authorized to transact business under all accounts of the Entity with the Bank.

X _____ Date
Name: David S Gast
Title: Member

X 12-29-14
Name: Efram Mordy Lahesky Date
Title: Member

X 12/30/14
Name: Sam Halper Date
Title: Authorized Signer

X _____
Name: Benjamin Landa Date
Title: Member

The PrivateBank

BUSINESS ENTITY ACCOUNT SIGNATURE CARD

DATE 12/29/2014	Financial Institution Branch Address 120 South LaSalle St Chicago, IL 60602 Opened By: Eugenia Spina

ACCOUNT INFORMATION
TITLE OF ACCOUNT Telegraph Realty, LLC
ACCOUNT NUMBER [redacted]3849
ACCOUNT T.I.N. [redacted]

600 Broadway
Lynbrook NY 11563-3980

PRODUCT NAME Business Checking ☐ Check box if the Account has a Beneficial Owner that is not the Entity

BUSINESS ENTITY INFORMATION (the "Entity")
Business Name and Address
Telegraph Realty, LLC

Assumed Name if D/B/A

600 Broadway
Lynbrook NY 11563-3980

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION
Under penalties of perjury, I certify that:
1. The number shown on this form is the correct taxpayer identification number for the Entity, (or I am waiting for a number to be issued to me), and
2. The Entity is not subject to backup withholding because: (a) it is exempt from backup withholding, or (b) it has not been notified by the Internal Revenue Service (IRS) that it is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified it that it is no longer subject to backup withholding, and
3. The Entity is a U.S. person.
4. The Entity is exempt from FATCA reporting.

You must cross out Item 2 above if the Entity has been notified by the IRS that it is currently subject to backup withholding because it failed to report all interest and dividends on its tax return.

12-29-14
SIGNATURE Efram Mordy Lahasky DATE

☐ See separate W-9 Document

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT. To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.
What this means for you: When you open an account, we will ask you for your name, address, date of birth, and other information that will allow us to identify you and the Entity. We may also ask to see your driver's license or other identifying documents.

ACKNOWLEDGMENT. The Entity agrees to be bound by the rules and conditions of The PrivateBank and Trust Company ("Bank") that govern this account, as they may be amended, including the Business Deposit Account Agreement and Disclosure ("Agreement and Disclosure"). By signing this document, I/We acknowledge on behalf of the Entity that the Agreement and Disclosure has been received. I/We certify that all of the information printed on this signature card and that I/We provided to the Bank is true and accurate, including, without limitation, the names and titles of each of the individuals who have signed below. I/We agree that the Bank has the right to charge this account for any liabilities owed to the Bank by the Entity. All signers are acting on behalf of the Entity.

Any one signature required for Account actions. If this Signature Card relates to a Certificate of Deposit, the individuals that execute below and, if applicable, the attached addendum, shall be authorized to transact business under any account for renewals of such Certificate of Deposit.

☒ Check box if the Entity desires that the individuals that execute below, and if applicable, the attached addendum, be authorized to transact business under all accounts of the Entity with the Bank.

12/31/2014

X D. Gast
Name: David S Gast Date
Title: Member

X
Name: Sam Hafner Date
Title: Authorized Signer

X 12/31/14
Name: Benjamin Landa Date
Title: Member

X 12/31/14
Name: Efram Mordy Lahasky Date
Title: Member

EXHIBIT 8

CHMS GROUP LLC

OPERATING AGREEMENT

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OPERATING AGREEMENT
OF
CHMS GROUP, LLC

This **OPERATING AGREEMENT** (this "**Agreement**") of CHMS GROUP, LLC, a New York limited liability company is entered into as of the 13th day of January, 2015 (the "**Effective Date**") by and among the signatories hereto.

Explanatory Statement

WHEREAS, the Members desire to enter into certain agreements with respect to the Company in connection with the foregoing;

NOW, THEREFORE, for good and valuable consideration, the parties, intending legally to be bound, hereby agree as follows:

Article I
Defined Terms

The following capitalized terms shall have the meanings specified in this Article I. Other terms are defined in the text of this Agreement, and, throughout this Agreement, those terms shall have the meanings respectively ascribed to them.

"**Act**" means the New York Limited Liability Company Law, as amended from time to time.

"**Adjusted Capital Account Deficit**" means, with respect to any Unit Holder, the deficit balance, if any, in such Unit Holder's Capital Account as of the end of the relevant taxable year, after giving effect to the following adjustments:

(i) credit to such Capital Account any amounts that such Unit Holder is deemed obligated to restore as described in the penultimate sentences of Regulation Sections 1.704-2(g)(1) and 1.704-2(i)(5); and

(ii) debit to such Capital Account the items described in Regulation Sections 1.704-1(b)(2)(ii)(d)(4), (5) and (6).

The foregoing definition of Adjusted Capital Account Deficit is intended to comply with Regulation Section 1.704-(1)(b)(2)(ii)(d) and shall be interpreted consistently therewith.

"**Affiliate**" means, with respect to any Member, any Person: (i) that owns or controls more than twenty-five percent (25%) of the voting or beneficial interests in the Member; (ii) in which the Member owns more than twenty-five percent (25%) of the voting or beneficial interests; (iii) that is a spouse, descendant (natural and adopted) or ancestor (natural and adopted) of such Member, or (iv) in which more than twenty-five percent (25%) of the voting or beneficial interests are owned or controlled by one or more Persons who has a relationship with the Member described in clause (i), (ii) or (iii) above.

"**Agreement**" means this Agreement, as amended from time to time.

"Available Cash" means all cash revenues, funds and proceeds received by the Company from any source whatsoever, including amounts received upon a Sale of the Company.

"Business" means providing management and consulting services to skilled nursing facilities and other similar business operations, and any other lawful business permitted under the Act.

"**Capital Account**" means the account maintained by the Company for each Member on the books of the Company. Each Unit Holder's Capital Account shall initially reflect an amount equal to such Unit Holder's initial Capital Contribution, and shall be (i) increased by any additional Capital Contributions made by such Unit Holder pursuant to the terms of this Agreement and such Unit Holder's share of Profits, the amount of any Company liabilities that are assumed by such Unit Holder and any other items of income and gain allocated to such Unit Holder pursuant to Article IV, and (ii) decreased by such Unit Holder's share of Losses, any distributions to such Unit Holder of cash or the Gross Asset Value of any other Company assets (net of liabilities assumed by such Unit Holder and liabilities to which such property is subject) distributed to such Unit Holder, the amount of any liabilities of such Unit Holder that are assumed by the Company and any other deduction allocated to such Unit Holder pursuant to Article IV. If any Unit or interest in the Company is transferred pursuant to the terms of this Agreement, the transferee shall succeed to the Capital Account of the transferor to the extent the Capital Account is attributable to the transferred Unit or interest in the Company. It is intended that the Capital Accounts of all Unit Holders shall be maintained in compliance with the provisions of Regulation Section 1.704-1(b), and all provisions of this Agreement relating to the maintenance of Capital Accounts shall be interpreted and applied in a manner consistent with that Regulation.

"**Capital Contribution**" means the total amount of cash and the initial Gross Asset Value of any other assets contributed (or deemed contributed under Regulation Section 1.704-1(b)(2)(iv)(d)) to the Company by a Member, net of liabilities assumed or to which the assets are subject. The term "**Capital Contribution**" shall include any Additional Capital, as defined in Section 3.2 hereof.

"**Chief Executive Officer**" or "**CEO**" means [Sam Halper], provided however, that in the event that such party is at any time no longer acting as the CEO of the Company, the term shall mean the party or parties then acting in such capacity.

"**Code**" means the United States Internal Revenue Code of 1986, as amended, or any corresponding provision of any succeeding law.

"**Company**" means CHMS Group, LLC.

"**Depreciation**" means, for each taxable year, an amount equal to the depreciation, amortization, or other cost recovery deduction allowable with respect to any asset of the Company for such taxable year, except that if the Gross Asset Value of any such asset differs from its adjusted basis for federal income tax purposes at the beginning of such taxable year,

Depreciation shall be an amount which bears the same ratio to such beginning Gross Asset Value as the federal income tax depreciation, amortization, or other cost recovery deduction for such taxable year bears to such beginning adjusted tax basis; provided, however, that if the adjusted basis for federal income tax purposes of any such asset at the beginning of such taxable year is zero, Depreciation shall be determined with reference to such beginning Gross Asset Value using any reasonable method selected by the Company and in accordance with GAAP.

"**Economic Risk of Loss**" has the meaning set forth in Regulation Section 1.752-2.

"**GAAP**" means United States generally accepted accounting principles, consistently applied.

"**Gross Asset Value**" means, with respect to any asset of the Company, such asset's adjusted basis for federal income tax purposes, except as follows:

(i) The initial Gross Asset Value of any asset contributed by a Unit Holder to the Company shall be the fair market value of such asset as agreed to by the contributing Unit Holder and the Managers;

(ii) The Gross Asset Values of all Company assets shall be adjusted to equal their respective fair market values as determined by the Managers as of the following times: (a) the acquisition of an additional Company interest in the Company by any existing Unit Holder or additional Unit Holder in exchange for more than a *de minimis* Capital Contribution; (b) the distribution by the Company to a Unit Holder of more than a *de minimis* amount of Company property (including cash) as consideration for a Company interest; and (c) the liquidation of the Company within the meaning of Regulation Section 1.704-1(b)(2)(ii)(g); provided, however, that the adjustments pursuant to clauses (a) and (b) above shall be made only if the Managers reasonably determine that such adjustments are necessary or appropriate to reflect the relative economic interests of the Unit Holders in the Company;

(iii) The Gross Asset Value of any Company asset distributed to any Unit Holder shall be adjusted to equal the fair market value of such asset on the date of distribution as agreed to by the distributee Unit Holder and the Managers;

(iv) If the Gross Asset Value of a Company asset has been determined or adjusted pursuant to clauses (i) or (ii) of this definition, such Gross Asset Value shall thereafter be adjusted by the Depreciation taken into account with respect to such asset for purposes of computing Profits and Losses; and

(v) The Gross Asset Values of the Company assets shall be increased (or decreased) to reflect any adjustments to the adjusted basis of such assets

pursuant to Sections 734(b) and 743(b) of the Code, but only to the extent that such adjustments are taken into account in determining Capital Accounts pursuant to Regulation Section 1.704-1(b)(2)(iv)(m), clause (vi) of the definition of "Profits and Losses" and Section 4.4(g) hereof; provided, however, that Gross Asset Values shall not be adjusted pursuant to this clause (v) to the extent that the Managers determine that an adjustment pursuant to clause (ii) above is necessary or appropriate in connection with a transaction that would otherwise result in an adjustment pursuant to this clause (v).

"**Manager**" or "**Managers**" means the [Sam Halper], provided however, that in the event that such party is at any time no longer acting as the manager of the Company, the term shall mean the party or parties then acting in such capacity.

"**Member**" or "**Members**" means each Person signing this Agreement as a member of the Company and any Person who subsequently is admitted as a member of the Company pursuant to the terms of this Agreement.

"**Membership Rights**" means all of the economic and non-economic rights (including, without limitation, voting rights) of a Member in the Company.

"**Minimum Gain**" has the meaning set forth in Regulation Section 1.704-2(b)(2).

"**Negative Capital Account**" means a Capital Account with a balance of less than zero.

"**Non-Managing-Member**" means a Member who is not a Manager.

"**Nonrecourse Deductions**" has the meaning set forth in Regulation Section 1.704-2(b)(1).

"**Percentage**" means, as to any Unit Holder, the percentage of Units held by such Unit Holder based on the total Units held by all Unit Holders.

"**Person**" means and includes any individual, corporation, partnership, association, limited liability company, trust, estate or other entity.

"**Permitted Transferee**" means, with respect to each Member, (i) any corporation, partnership, limited liability company or other entity which is wholly-owned by such Member, or (ii) any Person(s) if such Member is wholly owned by such Person(s).

"**Profits and Losses**" shall mean for each taxable year, an amount equal to the Company's taxable income or loss for such taxable year, determined in accordance with Code Section 703(a) (for this purpose, all items of income, gain, loss, or deduction required to be stated separately pursuant to Code Section 703(a)(1) shall be included in taxable income or loss), with the following adjustments:

(i) Any income of the Company that is exempt from federal income tax and not otherwise taken into account in computing such Profits and Losses shall be added to such taxable income or loss;

(ii) Any expenditures of the Company described in Code Section 705(a)(2)(B), or treated as Code Section 705(a)(2)(B) expenditures pursuant to Regulation Section 1.704-1(b)(2)(iv)(*i*), and which are not otherwise taken into account in computing such Profits and Losses, shall be subtracted from such taxable income or loss;

(iii) In the event the Gross Asset Value of any Company asset is adjusted pursuant to clause (ii) or (iii) of the definition of Gross Asset Value, the amount of such adjustment shall be taken into account as gain or loss from the disposition of such asset for purposes of computing Profits and Losses;

(iv) Gain or loss resulting from any disposition of any Company asset with respect to which gain or loss is recognized for federal income tax purposes shall be computed by reference to the Gross Asset Value of the Company asset disposed of, notwithstanding that the adjusted tax basis of such asset differs from its Gross Asset Value;

(v) In lieu of the depreciation, amortization, and other cost recovery deductions taken into account in computing such taxable income or loss, there shall be taken into account Depreciation for such taxable year;

(vi) To the extent an adjustment to the adjusted tax basis of any Company asset pursuant to Sections 734(b) and 743(b) of the Code is required pursuant to Regulation Section 1.704-1(b)(2)(iv)(m)(4) to be taken into account in determining Capital Accounts as a result of a distribution other than in liquidation of a Unit Holder's interest, the amount of such adjustment shall be treated as an item of gain (if the adjustment increases the basis of the asset) or loss (if the adjustment decreases the basis of the asset) from the disposition of the asset and shall be taken into account for purposes of computing Profits and Losses;

(vii) For purposes of this Agreement, any deduction for a loss on a sale or exchange of any Company asset which is disallowed to the Company under Code Section 267(a)(1) or 707(b) shall be treated as a Code Section 705(a)(2)(B) expenditure; and

(viii) Notwithstanding anything to the contrary in the definition of the term "Profits and Losses," any items which are specially allocated pursuant to Section 4.4 hereof shall not be taken into account in computing such Profits and Losses.

The amount of the items of Company income, gain, loss, or deduction available to be specially allocated pursuant to Article IV hereof shall be determined by applying rules analogous to those as set forth in this definition of Profits and Losses.

"**Regulation**" means the income tax regulations, including any temporary regulations, from time to time promulgated under the Code.

"Sale of the Company" means a transaction or series of related transactions involving (i) a transfer of all or substantially all of the assets of the Company, or (ii) a transfer of majority of the Units, whether by sale, merger, or otherwise.

"**Secretary**" means the Secretary of the State of New York.

"**Transfer**" means, when used as a noun, any voluntary sale, hypothecation, pledge, assignment, attachment or other transfer, and, when used as a verb, means, voluntarily to sell, hypothecate, pledge, assign or otherwise transfer.

"**Unit**" means an interest in the capital, profits, losses and distributions of the Company as provided herein.

"**Unit Holder**" means any Person who holds a Unit, whether as a Member or as an unadmitted assignee of a Member.

"**Unit Holder Nonrecourse Debt Minimum Gain**" has the meaning set forth in Regulation Section 1.704-2(i)(2).

"**Unit Holder Nonrecourse Deductions**" has the meaning set forth in Regulation Section 1.704-2(i)(1).

Article II
Formation and Name; Office; Purpose; Term

2.1 Organization. The Company has been formed as a limited liability company pursuant to the Act and the provisions of this Agreement by the filing of Certificate of Organization with the Secretary. The Managers shall use all reasonable efforts to assure that all filings, recordings, publishings and other acts necessary or appropriate for compliance with all requirements for the continuation of the Company as a limited liability company under the Act.

2.2 Name of the Company. The name of the Company shall be "CHMS Group, LLC". The Company may do business under the foregoing name and under any other name or names upon which the Managers select. If the Company does business under a name other than that set forth in its Certificate of Organization, then the Company shall comply with any requirements of the Act or applicable law.

2.3 Purpose. The purpose of the Company is to engage in the Business, to obtain any financing in connection therewith and to engage in any lawful act or activity related to the foregoing for which limited liability companies may be organized under the laws of the State of

New York, subject to the provisions of this Agreement.

2.4 Term. The term of the Company shall begin upon the filing of the Certificate of Organization with the Secretary and shall continue in perpetuity unless its existence is terminated pursuant to Article VII of this Agreement.

2.5 Principal Office and Place of Business. The principal office of the Company shall be located at such place which the Managers may select from time to time.

2.6 Registered Agent and Office. The name and address of the Company's registered agent shall as indicated in the Certificate of Organization. The Managers may change the registered agent and office of the Company at any time in its sole discretion.

2.7 Members. The name, present mailing address, Capital Contribution, Units and Percentage of each Member are set forth on Exhibit A attached hereto. Additional Members may be admitted to the Company only as provided in Article VI.

2.8 Fiscal Year. The fiscal year for the Company shall be based on the calendar year.

Article III
Members; Capital; Capital Accounts; Representation of Members

3.1 Capital Contributions. On or about the time of its execution of this Agreement, each Member shall make a capital contribution to the capital of the Company in the amount set forth opposite its name in the column labeled "**Capital Contribution**" on Exhibit A attached hereto.

3.2 Additional Capital Contributions. In the event the Managers determine that additional funds are required in connection with the Business, the Managers may request additional capital contributions or loans ("**Additional Loans**") by the Members. The Managers shall, by delivery of written notice to all of the Members (a "**Capital Call Notice**"), notify the Members of (x) the total amount so requested (the "**Additional Capital**"), (y) each Member's pro rata share of such amount, which shall be determined in accordance with the Members' respective Percentages, and (z) the date on which such funding will be requested (the "**Due Date**"), which date shall be no less than thirty (30) business days after the delivery of the Capital Call Notice. Each Member shall pay its pro rata share of the Additional Capital on or before the Due Date. If a Member declines to pay such pro rata share on or before the Due Date, such Member shall be deemed a non-contributing member (the "**Non-Contributing Member**") and the following shall occur:

(a) Any Members who have contributed their pro rata shares of the Additional Capital (the "**Contributing Members**") shall be entitled to contribute the Non-Contributing Member's share of the Additional Capital (the "**Contribution Shortfall**"); provided, that if the aggregate funds available from the Contributing Members exceed the amount of the Additional Contribution, each Contributing Member shall only be entitled to provide funds in accordance with its Percentage. Upon the funding of a Contribution Shortfall by the Contributing Members, a Percentage of Units in the Company equal to: i)

the amounts funded by any Contributing Members, divided by ii) all Capital Contributions made to the Company including the Additional Capital, shall be deducted from the Units of the Non-Contributing Member(s), and added to the Units of the Contributing Member(s) funding the Contribution Shortfall.

3.3 Admission of New Members. If the full amount of the Contribution Shortfall cannot be raised from the Members, the Managers shall have the right to raise the capital needed from third parties by admitting them as new members and issuing Units in the Company to such third parties.

3.4 No Interest on Capital Contribution. No Member shall be paid interest on its Capital Contribution.

3.5 Return of Capital Contributions; Form of Return of Capital. Except as otherwise provided in this Agreement, no Member shall have the right to receive the return of any Capital Contribution. If a Member is entitled to receive a return of a Capital Contribution, the Member shall not have the right to receive anything but cash in return of the Member's Capital Contribution.

3.6 Capital Accounts. A separate Capital Account shall be maintained for each Member. No Unit Holder shall be obligated to restore a Negative Capital Account, unless otherwise required by law or Article IV hereof.

3.7 Loans. Any Member may, at any time, make or cause a loan to be made to the Company in any amount and on those commercially reasonable terms upon which the Managers and the Members agree.

3.8 Liability of Members for Company Obligations. The Members shall not be liable for the repayment and discharge of debts and obligations of the Company.

3.9 No Third Party Beneficiaries. The provisions set forth in this Article III are solely and exclusively for the benefit of the Company and the Members, and are not intended to confer any rights on any third party. Without limiting the generality of the foregoing, no creditor of the Company shall be deemed a third party beneficiary of any obligation of the Members to contribute capital or make advances to the Company.

3.10 Representation of Members. EACH MEMBER HEREBY REPRESENTS AS FOLLOWS: (A) THAT SUCH MEMBER HAS SUCH KNOWLEDGE AND EXPERIENCE IN FINANCIAL AFFAIRS THAT IT IS CAPABLE OF EVALUATING THE MERITS AND RISKS OF MAKING ITS CAPITAL CONTRIBUTION; (B) THAT NO MEMBER HAS RELIED IN CONNECTION WITH ITS DECISION TO MAKE A CAPITAL CONTRIBUTION UPON ANY REPRESENTATIONS, WARRANTIES OR AGREEMENTS BY ANY PERSON, INCLUDING WITHOUT LIMITATION, THE MANAGERS; (C) THAT SUCH MEMBER CAN AFFORD TO BEAR THE ECONOMIC RISK OF HOLDING ITS UNITS FOR AN INDEFINITE PERIOD OF TIME (D) THAT SUCH MEMBER CAN AFFORD TO SUFFER THE COMPLETE LOSS ITS CAPITAL CONTRIBUTION.; AND (E) THAT SUCH MEMBER IS AN "ACCREDITED INVESTOR" AS SUCH TERM IS DEFINED

IN RULE 501(A) OF REGULATION D PROMULGATED UNDER THE U.S. SECURITIES ACT OF 1933, AS AMENDED (THE "**SECURITIES ACT**").

Article IV
Distributions and Allocations

4.1 Distributions of Available Cash. The Managers shall have the right to determine whether, and to what extent, distributions of Available Cash shall be made to Members. When and to the extent the Managers determine in their sole discretion that, after providing for the Company's present and anticipated debts (other than the Initial Loans and the Additional Loans which shall not have priority of payment) and obligations, capit al needs, expenses and reasonable reserves for contingencies, it is appropriate and in the best interests of the Company to make distributions of Available Cash, then such distributions shall be made, pro rata to the Members in accordance with their Percentages.

Nothing contained herein shall limit the Managers' discretion set forth in this Section 4.1 of the Agreement.

4.2 Distributions with Respect to Tax. Notwithstanding the provisions of Section 4.1 hereof, the Managers shall use best efforts to cause the Company to distribute sufficient cash to enable the Unit Holders to pay Federal and state income taxes arising from the Company's profits allocated to the Unit Holders during a taxable year, in an amount equal to the net taxable income of the Company allocated to each Unit Holder for such year times the highest marginal Federal and state income tax rates for such year applicable to an individual resident of the State of New York. Such distribution shall be paid with respect to a taxable year of the Company at such times and in such amounts as determined in good faith by the Managers to be appropriate to enable the Unit Holders to pay estimated income tax liabilities.

4.3 Allocations of Profit and Losses. After giving effect to the special allocations set forth in Section 4.4, taxable income or loss, and other items of income and deduction, shall generally be allocated amongst the Unit Holders in accordance with the provisions of Section 4.1 hereof. The Managers are hereby authorized, upon the advice of the Company's tax counsel, to amend this Article IV to comply with the Code and the Regulations promulgated under Code Section 704(b); provided, however, that no amendment shall materially affect distributions to a Unit Holder without the Unit Holder's prior written consent. To the extent any Member is unable to take a loss due to Capital Account limitations, any remaining loss shall be allocated to Members upon the advice of the Company's tax advisors.

4.4 Regulatory and Other Special Allocations. The allocations pursuant to Section 4.3 hereof shall be subject to the following special allocations made in the following order of priority:

(a) Except as otherwise provided in Regulation Section 1.704-2(f), if there is a net decrease in Minimum Gain during any taxable year, each Unit Holder shall be specially allocated items of Company income and gain for such taxable year (and, if necessary, subsequent taxable years) in an amount equal to such Unit Holder's share of the net decrease in Minimum Gain, determined in accordance with Regulation Section

1.704-2(g). Allocations pursuant to the previous sentence shall be made in proportion to the respective amounts required to be allocated to each Unit Holder pursuant thereto. The items so allocated shall be determined in accordance with Regulation Sections 1.704-2(f)(6) and 1.704-2(j)(2). This Section 4.4(a) is intended to comply with the minimum gain chargeback requirement in Regulation Section 1.704-2(f) and shall be interpreted consistently therewith.

(b) Except as otherwise provided in Regulation Section 1.704-2(i)(4), if there is a net decrease in Unit Holder Nonrecourse Debt Minimum Gain attributable to Unit Holder Nonrecourse Debt during any taxable year, each Unit Holder which has a share of Unit Holder Nonrecourse Debt Minimum Gain attributable to such Unit Holder Nonrecourse Debt, determined in accordance with Regulation Section 1.704-2(i)(5), shall be specially allocated items of Company income and gain for such taxable year (and, if necessary, subsequent taxable years) in an amount equal to such Unit Holder's share of the net decrease in Unit Holder Nonrecourse Debt Minimum Gain, determined in accordance with Regulation Section 1.704-2(i)(4). Allocations pursuant to the previous sentence shall be made in proportion to the respective amounts required to be allocated to each Unit Holder pursuant thereto. The items so allocated shall be determined in accordance with Regulation Sections 1.704-2(i)(4) and 1.704-2(j)(2). This Section 4.4(b) is intended to comply with the minimum gain chargeback requirement in Regulation Section 1.704-2(i)(4) and shall be interpreted consistently therewith.

(c) In the event that any Unit Holder unexpectedly receives any adjustments, allocations or distributions described in Regulation Sections 1.704-1(b)(2)(ii)(d)(4), (5) or (6), items of Company income and gain shall be specially allocated to such Unit Holder in an amount and manner sufficient to eliminate, to the extent required by the Regulation promulgated under Section 704(b) of the Code, the deficit balance, if any, in such Unit Holder's Adjusted Capital Account as quickly as possible; provided, that an allocation pursuant to this Section 4.4(c) shall be made only if and to the extent that such Unit Holder would have an Adjusted Capital Account Deficit after all other allocations provided for in this Section 4.4 have been tentatively made as if this Section 4.4(c) were not in this Agreement.

(d) In the event that any Unit Holder has a deficit Capital Account at the end of any taxable year that is in excess of the sum of (i) the amount such Unit Holder is obligated to restore pursuant to any provision of this Agreement and (ii) the amount such Unit Holder is deemed to be obligated to restore pursuant to the penultimate sentences of Regulation Sections 1.704-2(g)(1) and 1.704-2(i)(5), such Unit Holder shall be specially allocated items of Company income and gain in the amount of such excess as quickly as possible, provided that an allocation pursuant to this Section 4.4(d) shall be made only if and to the extent that such Unit Holder would have a deficit Capital Account in excess of such sum after all other allocations provided for in this Section 4.4 have been tentatively made as if Section 4.4(c) and this Section 4.4(d) were not in this Agreement.

(e) Nonrecourse Deductions for any taxable period shall be allocated to the Unit Holders in accordance with their respective Percentages. If the Managers determine

in their good faith discretion that the Nonrecourse Deductions must be allocated in a different ratio to satisfy the safe harbor requirements in the Regulation promulgated under Section 704(b) of the Code, the Managers are authorized to revise the prescribed ratio to the numerically closest ratio that satisfies such requirements.

(f) Any Unit Holder Nonrecourse Deductions for any taxable period shall be allocated 100% to the Unit Holder that bears the Economic Risk of Loss with respect to the Unit Holder Nonrecourse Debt to which such Unit Holder Nonrecourse Deductions are attributable in accordance with Regulation Section 1.704-2(i). If more than one Unit Holder bears the Economic Risk of Loss with respect to a Unit Holder Nonrecourse Debt, such Unit Holder Nonrecourse Deductions attributable thereto shall be allocated between or among such Unit Holders in accordance with the ratios in which they share such Economic Risk of Loss.

(g) To the extent an adjustment to the adjusted tax basis of any Company asset pursuant to Section 734(b) or 743(b) of the Code is required pursuant to Regulation Section 1.704-1(b)(2)(iv)(*m*) to be taken into account in determining Capital Accounts as a result of a distribution to a Unit Holder in complete liquidation of its interest, the amount of such adjustment to Capital Accounts shall be treated as an item of gain (if the adjustment increases the basis of such asset), or loss (if the adjustment decreases the basis of such asset), and such item of gain or loss shall be specially allocated to the Unit Holders in accordance with their Percentages in the event Regulation Section 1.704-1(b)(2)(iv)(*m*)(2) applies, or to the Unit Holder to whom such distribution was made in the event that Regulation Section 1.704-1(b)(2)(iv)(*m*)(4) applies.

(h) If any item of taxable income, gain, deduction or loss is imputed to a Unit Holder and such imputed income, gain, deduction or loss directly relates to a transaction between such Unit Holder and the Company, any corresponding item of income, gain, deduction or loss recognized by the Company, net of any income or deduction recognized by the Company in connection with such transaction, shall be allocated to such Unit Holder up to an amount of such imputed income, gain, deduction or loss, and any related deemed cash contribution or distribution (as the case may be) shall be treated as having been made by or to such Unit Holder.

(i) In accordance with Code Section 704(c) and the Regulations thereunder, income, gain, loss, and deduction with respect to any asset contributed to the capital of the Company shall, solely for tax purposes, be allocated among the Unit Holders so as to take account of any variation between the adjusted basis of such property to the Company for federal income tax purposes and its initial Gross Asset Value. If the Gross Asset Value of any Company asset is adjusted pursuant to clause (ii) of the definition of Gross Asset Value, subsequent allocations of income, gain, loss, and deduction with respect to such asset for federal income tax purposes shall take account of any variation between the adjusted basis of such asset for federal income tax purposes and its Gross Asset Value in the same manner as under Code Section 704(c) and the Regulations thereunder. Any elections or other decisions relating to such allocations shall be made by the Managers in any manner that reasonably reflects the purpose and intention of this Agreement.

Allocations pursuant to this Section 4.4(i) are solely for purposes of federal, state, local and foreign taxes and shall not affect, or in any way be taken into account in computing, any Unit Holder's Capital Account or share of Profits and Losses or other items or distributions pursuant to any provision of this Agreement.

4.5 Distributions of Proceeds from a Sale Transaction. To the extent there is Available Cash which are the proceeds from any transaction involving the Sale of the Company, and to the extent the Managers determine in their sole discretion that, after providing for the Company's present and anticipated debts (other than the Initial Loans and the Additional Loans which shall not have priority of payment) and obligations, capital needs, expenses and reasonable reserves for contingencies, it is appropriate and in the best interests of the Company to make distributions of Available Cash, then such distributions shall be made to the Unit Holders in accordance with the provisions of Section 4.1 hereof.

4.6 Distributions of Proceeds from a Refinance Transaction. To the extent there is Available Cash which are the proceeds from any transaction involving the refinance or restructuring of any debt of the Company, and to the extent the Managers determine in their sole discretion that, after providing for the Company's present and anticipated debts (other than the Initial Loans and the Additional Loans which shall not have priority of payment) and obligations, capital needs, expenses and reasonable reserves for contingencies, it is appropriate and in the best interests of the Company to make distributions of Available Cash, then such distributions shall be made to the Unit Holders in accordance with in accordance with the provisions of Section 4.1 hereof

4.7 Liquidation and Dissolution. If the Company is liquidated, the Company shall cause a final accounting to be made, and any allocation of Profits and Losses shall be made in accordance with Section 4.3 and the assets of the Company shall be distributed to the Unit Holders pro rata based on positive Capital Account balances of the Members.

4.8 Distributions In Kind. If any assets of the Company are distributed in kind to the Unit Holders, those assets shall be valued on the basis of their fair market value, and any Unit Holder entitled to any interest in those assets may receive that interest as a tenant-in-common with all other Unit Holders so entitled.

Article V
Management by Managers; Members

5.1 Management of the Company.

(a) The business and affairs of the Company shall be managed by the Manager and CEO, and all powers of the Company shall be exercised by or under the authority of the Manager and CEO. The CEO shall have an annual meeting at the principal place of business of the Company or at such other location consented to by the Manager, such consent to be evidenced by written instrument or by the Manager's attendance at such location. Any action taken by the Manager or CEO shall constitute the act of, and shall be deemed to fully bind, the Company, unless such action required approval of the Members pursuant to this Agreement.

Except for the Manager and CEO, no other Person shall have any right or authority to act for or bind the Company except as permitted in this Agreement or as required by law. Except as provided in Section 5.8, the Members shall have no power to remove the Manager as manager of the Company.

(b) The CEO shall have the right to manage the day-to-day operations of the Company, and in accordance, as applicable, with the annual budget approved by the Members, and shall have any and all rights and powers to act on behalf of the Company, including, but not limited to, the right and the power to:

(i) supervise the operation and management of the Company;

(ii) cause the Company or its properties to be insured and to make determinations with respect to insurance companies, deductibles, types of coverage, claims, settlements and other similar matters;

(iii) determine the appropriate amount of reserves to be maintained thereby for anticipated future expenses, costs and taxes;

(iv) determine the Company's operating and capital expenditures budgets and annual marketing plans;

(v) acquire by purchase, lease or otherwise, any personal property, tangible or intangible, required by the Company to carry out the Business;

(vi) subject to Section 5.10 of this Agreement, enter into any contract on behalf of the Company, including, without limitation, management or consultant contracts;

(vii) obtain licenses, approvals and permits necessary for the Business;

(viii) make decisions on behalf of the Company relating to compliance issues with governmental agencies or programs and/or licensure requirements;

(ix) hire and fire all employees of the Company, as well as all officers and directors, if any; and

(x) execute, enter into, acknowledge and deliver all contracts, agreements and instruments necessary or appropriate to accomplish any of the foregoing.

Notwithstanding foregoing, the Non-Managing Members, by unanimous agreement, may override any decision of the CEO with regard to the day to day decisions provided for in this Section 5.1 so long as such decision by the Non-Managing

Members does not cost the Company more money than the decision of the CEO.

5.2 Limitation on Authority of Members.

(a) Unless a Member is also a Manager, no Member shall be an agent of the Company solely by virtue of being a Member, and no Member shall have authority to act for the Company solely by virtue of being a Member.

(b) This Agreement, and specifically Section 5.1 of this Agreement, supersedes any authority granted to the Members pursuant to the Act. Any Member who takes any action or binds the Company in violation of this Agreement shall be solely responsible for any loss and expense, including reasonable attorney fees, incurred by the Company as a result of the unauthorized action and shall indemnify and hold the Company harmless with respect to the loss or expense.

5.3 Duties of Parties. Nothing herein shall be deemed to restrict in any way the rights of any Member or Manager, any Affiliate, or any member or shareholder of any Member, Manager or any of their respective Affiliates to conduct any other business or activity whatsoever, including, without limitation, such business or activity that is substantially similar to the Business, and no Member or Manager shall be deemed to have any obligation (fiduciary or otherwise) or liability to the Company or to any other Member with respect to that business or activity. The organization shall be without prejudice to the respective rights of the Members and the Managers (or the rights of their respective Affiliates) to maintain, expand or diversify such other interests and activities and to receive and enjoy profits or compensation therefrom. Each of the Members and Managers waive any right that they might otherwise have to share or participate in such other interests or activities of any of the other Members or Managers, their Affiliates or any member or shareholder of their respective Affiliates.

5.4 Indemnification of the Managers. The Company shall indemnify and hold harmless the Managers and their officers, members, operating directors, employees and agents from and against any loss, expense, damage or injury suffered or sustained by them by reason of any acts, omissions or alleged acts or omissions arising out of its activities on behalf of the Company, including, without limitation, any judgment, award, settlement, reasonable attorneys' fees and other costs or expenses incurred in connection with the defense of any actual or threatened action, proceeding or claim, if the acts, omissions or alleged acts or omissions upon which such actual or threatened action, proceeding or claim is based were for a purpose reasonably believed, in good faith, to be in the best interests of the Company and were not performed or omitted fraudulently or as a result of gross negligence or material misconduct. The Company may advance sums for payment of amounts described in this Section 5.4, provided that the recipient of any such advances shall be obligated to repay the amounts advanced if the recipient is finally adjudged ineligible to be indemnified hereunder.

5.5 Power of Attorney.

(a) Grant of Power. Each Member constitutes and appoints each Manager as the Member's true and lawful attorney-in-fact ("**Attorney-in-Fact**"), and in the

Member's name, place and stead, to make, execute, sign, acknowledge, and file, with respect to the Company:

(i) one or more Certificate of Organization;

(ii) all documents including amendments to Certificate of Organization which the Attorney-in-Fact deems appropriate to reflect any amendment, change, or modification of this Agreement as permitted under Section 10.11 of this Agreement;

(iii) any and all other certificates or other instruments required to be filed by the Company under the laws of the State of New York or of any other state or jurisdiction, including, without limitation, any certificate or other instruments necessary in order for the Company to continue to qualify as a limited liability company under the laws of the State of New York;

(iv) one or more applications to use an assumed name; and

(v) subject to the provisions of Section 8.1, all documents which may be required to dissolve and terminate the Company and to cancel its Certificate of Organization.

(b) Irrevocability. The foregoing power of attorney is irrevocable and is coupled with an interest, and, to the extent permitted by applicable law, shall survive the death or disability of a Member. It also shall survive the Transfer of a Unit, except that if the transferee is approved for admission as a Member, this power of attorney shall survive the delivery of the assignment for the sole purpose of enabling the Attorney-in-Fact to execute, acknowledge and file any documents needed to effectuate the substitution. Each Member shall be bound by any representations made by the Attorney-in-Fact acting in good faith pursuant to this power of attorney, and each Member hereby waives any and all defenses which may be available to contest, negate or disaffirm the action of the Attorney-in-Fact taken in good faith under this power of attorney.

5.6 Management Fee. The Manager shall not be paid a management fee. The Managers shall be entitled to reimbursement of actual costs and expenses with respect to those incurred in connection with their responsibilities or duties as Managers.

5.7 Withdrawal by a Manager.

(a) Subject to Section 5.7(b), each Manager may withdraw as a manager of the Company at any time upon thirty (30) days written notice to the Members, in which case a replacement Manager shall be selected by the Members holding a majority of the Percentage.

(b) Notwithstanding Section 5.7(a), each Manager hereby covenants that such Manager shall not take any action to withdraw as a manager of the Company unless:

(i) If the Manager is the sole Manager at the time,

(A) The Members have, prior to the Manager's withdrawal, elected a substitute Manager which has at least one percent (1%) of the Percentages; and

(B) The withdrawal of the Manager as a manager of the Company will not affect the classification of the Company as a limited liability company pursuant to the Act or for federal income tax purposes; or

(ii) If the withdrawing Manager is not the sole Manager at such time,

(A) All remaining Managers have agreed to the Manager's withdrawal; and

(B) The withdrawal of the Manager as a manager of the Company will not affect the classification of the Company as a limited liability company pursuant to the Act or for federal income tax purposes.

5.8 Reconstitution of Company After Withdrawal or Death of a Manager. Upon the withdrawal or death of the last remaining Manager or other terminating event under Sections 5.7, the business of the Company may be continued, in a reconstituted form if necessary, if, within ninety (90) days after the withdrawal or death of the Manager, the withdrawn Managers (or their heirs, as applicable) agree in writing to continue the business of the Company and to the appointment of one or more additional managers. Immediately upon the foregoing agreement to continue the business, the Members, and/or any successor Manager shall prepare, execute, and file for recordation amended or new Certificate of Organization if required, and shall take or cause to be taken all steps required in connection with the continuation of the business in accordance with the applicable laws of the State of New York.

5.9 Members; Meetings and Voting.

(a) Notwithstanding anything to the contrary in this Agreement, the Manager shall not take any action with respect to the following matters, absent the unanimous agreement of the Members, which approval may be given or withheld in each Member's sole discretion:

(i) any filing of a petition seeking relief for the Company under any law for relief of debtors;

(ii) any redemption, purchase for cancellation or other acquisition by the Company of Units or other equity interests in the Company for more than $500,000;

(iii) any recapitalization of the Company;

(iv) any initiation of a lawsuit, claim, arbitration or mediation procedure or other similar action before any court of competent jurisdiction, administrative agency, third party arbitrator or mediator or other similar tribunal, if the value of such claim is at least $100,000;

(v) any merger affecting the Company;

(vi) any sale of all or substantially all of the assets of the Company;

(vii) borrowing money and/or entering into financing or refinancing transactions with any bank or commercial lender on behalf of the Company;

(viii) the Company's engagement in any business activity that represents a material deviation from the Business;

(ix) request Additional Capital Contributions from the Members pursuant to Section 3.2(a);

(x) entering into any contract on behalf of the Company, including, without limitation, management or consultant contracts binding the company in the aggregate amount equal or greater to $100,000;

(xi) subject to Section 3.3, authorize the issuance of Additional Interests and admit additional Members;

(xii) the entering into any agreement or commitment binding upon the Company with respect to the foregoing; and

(xiii) any other matter that approval by the Members is specifically required by this Agreement..

(b) A meeting of the Members may be called at any time by the Managers or by a majority of the Members. Meetings of Members shall be held at the Company's principal place of business, the Company's principal office, or at any other place designated by the Person(s) calling the meeting. Not less than ten (10) nor more than sixty (60) days before each meeting, the Person(s) calling the meeting shall give written notice of the meeting to each Member entitled to vote at the meeting. The notice shall state the time, place and purpose of the meeting. Notwithstanding the foregoing provisions, each Member who is entitled to notice waives notice if before or after the meeting the Member signs a waiver of the notice which is filed with the records of Members' meetings, or is present at the meeting in person or by proxy. A Member may vote either in person or by written proxy signed by the Member or by his duly authorized attorney-in-fact.

(c) In lieu of holding a meeting, the Members may vote or otherwise take action by a written instrument indicating the consent of Members representing a majority of the Percentage, or such other percentage as may re required in this Agreement, of the Members.

5.10 Personal Services of Members. Unless a Member is also a Manager, no Member shall be required to perform services for the Company solely by virtue of being a Member.

Article VI
Transfer of Units and Withdrawals of Members

6.1 Transfers in General.

(a) Except as provided in Section 6.2 and Section 6.3, no Person may Transfer all or any portion of or any interest or rights in the Person's Membership Rights or Units unless the following conditions ("**Conditions of Transfer**") are satisfied:

(i) The Transfer will not require registration of Units or Membership Rights under any Federal or state securities laws;

(ii) The transferee delivers to the Company a written instrument agreeing to be bound by the terms of this Agreement;

(iii) The Transfer will not result in the Company being subject to the Investment Company Act of 1940, as amended; and

(iv) The transferor or the transferee delivers the transferee's taxpayer identification number and the transferee's initial tax basis in the Transferred Units to the Company.

(b) If the Conditions of Transfer are satisfied, then a Member or Unit Holder may Transfer all or any portion of that Person's Units. Notwithstanding the foregoing to the contrary, a Member may not Transfer all or any portion of its Membership Rights without the prior consent of the Managers. Absent the required consent, any such proposed Transfer shall be void as a matter of law. If a transfer of all Membership Rights is approved as aforesaid, the transferee will succeed to all Membership Rights of the Member who transfers such Membership Rights.

(c) Each Member hereby acknowledges the reasonableness of the prohibition contained in this Section 6.1 in view of the purposes of the Company and the relationship of the Members. Any Person to whom Membership Rights are attempted to be transferred in violation of this Section 6.1 shall not be entitled to exercise any Membership Rights other than the rights to share in the profits and the losses of the Company, to receive distributions of Company funds and to assign an interest pursuant to this Article VI.

6.2 Permitted Transferees; Transfers to Individuals Related to Members.

(a) Notwithstanding anything contained herein to the contrary, each Member shall, upon ten (10) days prior written notice to each of the other Members and the Managers, have the right to Transfer all or a portion of such Member's Membership rights to any Permitted Transferee with respect to such Member, without first obtaining the prior consent of the Managers as provided in Section 6.1(b); provided, however, the terms and conditions of Section 6.1(a)(i) – (iv) must be satisfied first.

(b) In addition to the foregoing, any Member may assign its rights to receive distributions of Available Cash (as provided in Article IV above) to any Person designated in writing by such Member to the Managers.

6.3 Involuntary Withdrawal.

(a) Immediately upon the occurrence of an Involuntary Withdrawal (as defined herein), then the successor of the withdrawn Member shall thereupon become a Unit Holder but shall not become a Member nor shall such successor be entitled to exercise any Membership Rights other than the rights to share in the profits and the losses of the Company, to receive distributions of Company funds and to assign an interest pursuant to this Article VI. Specifically, such successor-in-interest shall not be entitled to vote on any matter as provided in this Agreement and such successor-in-interest's Units shall not be considered in determining a majority of the Percentages. The successor-in-interest shall become a substituted Member only upon compliance with the applicable provisions of Article VI. As used herein, "**Involuntary Withdrawal**" means a Member's dissociation with the Company by means other than a Transfer or upon the occurrence of any of the following events: (i) the Member (A) makes an assignment for the benefit of creditors; (B) files a voluntary petition of bankruptcy; (C) is adjudged bankrupt or insolvent or there is entered against the Member an order for relief in any bankruptcy or insolvency proceeding; (D) seeks, consents to or acquiesces in the appointment of a trustee for, receiver for, or liquidation of, the Member or all or any substantial part of the Member's properties; (E) files an answer or other pleading admitting or failing to contest the material allegations of a petition filed against the Member in any proceeding described in subsections (A) through (D); (ii) if the Member is an individual, (A) the death or incapacity of such individual or (B) a final entry of judgment in a proceeding involving the dissolution of such individual's marriage, if such judgment shall result in a Transfer of such individual's Units; (iii) if the Member is acting as a Member by virtue of being a trustee of a trust, termination of the trust; (iv) if the Member is a partnership or another limited liability company, the dissolution and commencement of the winding up of the partnership or limited liability company; or (v) if the Member is a corporation, the dissolution of the corporation or the revocation of its charter.

(b) In addition to the foregoing, upon any Involuntary Withdrawal by a Member, the Company may elect to acquire such Member's Units for fair market value, as determined by a third party appraiser with experience valuing businesses such as the Company, but in no event less than the amount of the Capital Contributions made by the Member whose Units are being acquired.

6.4 Change in Control of Entity Members. Each of the Members to the extent that any such Member is a corporation, partnership, limited liability company, trust or any other entity hereby covenants and agrees that it shall not permit any transfers of equity interests in any such Member if as a consequence thereof, such transfer would result in a change of voting control of such Member, including without limitation any Permitted Transferee that has become a Unit Holder or has been admitted as a substituted Member, absent the prior consent of the Managers. If any such Member permits any such transfer without the required prior consent, then such Member shall have no right to exercise any Membership Interests other than the rights to share in the profits and the losses of the Company, to receive distributions of Company funds and to assign an interest pursuant to this Article VI

Article VII

Reserved

Article VIII
Dissolution, Liquidation, and Termination of the Company

8.1 Events of Dissolution. The Company shall be dissolved upon the happening of any of the following events:

(a) Unanimous consent of a Members; or

(b) the dissolution or bankruptcy of all of the Managers, unless a substitute Manager(s) is selected by agreement of the remaining Members (without regard to any dissolved or bankrupt Manager) and the new Manager(s) elects to continue the business of the Company.

8.2 Procedure for Winding Up and Dissolution. If the Company is dissolved, the Managers shall wind up the affairs of the Company. If at such time, there is no Manager, then a the remaining Members shall select a Person to wind up the affairs of the Company. On winding up of the Company, the assets of the Company shall be distributed: first, to pay the costs and expenses of the winding up, liquidation and termination of the Company; second, to creditors of the Company, including Unit Holders who are creditors, in satisfaction of the liabilities of the Company; third, to establish reserves reasonably adequate to meet any and all contingent or unforeseen liabilities or obligations of the Company; and then to the Unit Holders in accordance with Section 4.7.

8.3 Filing of Articles of Dissolution. If the Company is dissolved, the Managers shall promptly file Articles of Dissolution with the Secretary. If there is no Manager, then the Articles of Dissolution shall be filed by the remaining Members; if there are no remaining Members, the Articles shall be filed by the last Person to be a Member; if there is neither a Manager, remaining Members, or a Person who last was a Member, the Articles shall be filed by the legal or personal representatives of the Person who last was a Member.

Article IX
Books, Records, Accounting, and Tax Elections

9.1 Bank Accounts. All funds of the Company shall be deposited in a bank account or accounts maintained in the Company's name. The Managers shall determine the institution or institutions at which the accounts will be opened and maintained, the types of accounts, and the Persons who will have authority with respect to the accounts and the funds therein.

9.2 Books and Records.

(a) The Managers shall keep or cause to be kept complete and accurate books and records of the Company and supporting documentation of the transactions with respect to the conduct of the Company's business. The records shall include, but not be limited to, complete and accurate information regarding the state of the business and

financial condition of the Company, a copy of the Certificate of Organization and this Agreement and all amendments thereto, a current list of the names and last known business, residence, or mailing addresses of all Members, and the Company's Federal, state or local tax returns.

(b) The books and records shall be maintained in accordance with sound accounting practices and shall be available at the Company's principal office for examination by any Member or the Member's duly authorized representative at any and all reasonable times during normal business hours provided three (3) business days of advance notice is given. Each Member shall reimburse the Company for all costs and expenses incurred by the Company in connection with the Member's inspection and copying of the Company's books and records.

9.3 Annual Accounting Period. The annual accounting period of the Company shall be its taxable year. The Company's taxable year shall be selected by the Managers, subject to the requirements and limitations of the Code.

9.4 Tax Matters Person. The Manager shall be the Company's "tax matters person" ("**Tax Matters Person**") and, as such, shall have all powers and responsibilities provided in Code Section 6221, et seq. or such other provisions as may become applicable to limited liability companies. The Tax Matters Person shall keep all Members informed of all notices from government taxing authorities which may come to the attention of the Tax Matters Person. The Company shall pay and be responsible for all reasonable third-party costs incurred by the Tax Matters Person in performing those duties. A Member shall be responsible for any costs incurred by the Member with respect to any tax audit or tax-related administrative or judicial proceeding against any Member, even though it relates to the Company. The Company shall indemnify and hold harmless the Tax Matters Person from and against any liabilities or costs associated with the performance of the duties described in this Section 9.4, unless such liabilities or costs have arisen from fraud, gross negligence or material misconduct of the Tax Matters Person.

9.5 Tax Elections. The Managers shall have the authority to make all Company elections permitted under the Code, including, without limitation, elections of methods of depreciation and elections under Code Section 754.

9.6 Title to Company Property. All real and personal property acquired by the Company shall be acquired and held by the Company in its name.

Article X
Intentionally Omitted

Article XI
General Provisions

11.1 Further Assurances. Each Member shall execute all such certificates and other documents and shall do all such filing, recording, publishing and other acts as the Managers deem appropriate to comply with the requirements of law for the formation and operation of the Company and to comply with any laws, rules, and regulations relating to the acquisition,

operation, or holding of the property of the Company.

11.2 Notifications. Any notice, demand, consent, election, offer, approval, request, or other communication (collectively, a "**notice**") required or permitted under this Agreement must be in writing and either: 1) delivered personally, 2) sent by certified or registered mail, postage prepaid, return receipt requested, 3) sent by recognized overnight delivery service, 4) sent by electronic mail with confirmed receipt transmission report or 5) by facsimile with confirmed receipt transmission report. A notice must be addressed to a Unit Holder at the Unit Holder's last known address on the records of the Company. A notice to the Company must be addressed to the Company's principal office. A notice delivered personally will be deemed given only when acknowledged in writing by the person to whom it is delivered. A notice that is sent by mail will be deemed given: (i) three (3) business days to an address within the United States of America or (ii) seven (7) business days to an address outside of the United States of America after it is mailed. A notice sent by recognized overnight delivery service will be deemed given when received or refused. A notice sent by electronic mail or facsimile shall be deemed given when sent, provided a confirmed receipt transmission report is generated. Any party may designate, by notice to all of the others, substitute addresses or addressees for notices; and, thereafter, notices are to be directed to those substitute addresses or addressees.

11.3 Specific Performance. The parties recognize that irreparable injury will result from a breach of any provision of this Agreement and that money damages will be inadequate to fully remedy the injury. Accordingly, in the event of a breach or threatened breach of one or more of the provisions of this Agreement, the Company or any party who may be injured (in addition to any other remedies which may be available to that party) shall be entitled to one or more preliminary or permanent orders (i) restraining and enjoining any act which would constitute a breach or (ii) compelling the performance of any obligation which, if not performed, would constitute a breach, and that the Company or such injured party shall not be required to post bond or other security in connection therewith.

11.4 Dispute Resolution.

(a) The parties hereto agree that all problems or claims arising out of or in connection with this Agreement and all other agreements or other instruments executed in connection herewith, including any claim for specific performance (collectively "**Disputes**"), the Members shall, in good faith, use their reasonable best efforts to resolve the Dispute. If after such efforts the Members are unable within ten (10) days of the arising of the Dispute to resolve the Dispute in good faith, any party may submit the dispute to a an arbitration panel for resolution. In the event the parties are unable to agree upon an arbitration panel, each of the parties to the dispute shall select one arbitrator, and such two arbitrators shall select a third arbitrator, whom together shall constitute the panel. The fees and expenses of such dispute resolution shall be borne by the non-prevailing party, as determined by such arbitration.

11.5 Choice of Law. The interpretation, enforcement and performance of this Agreement shall be governed by the laws of the State of New York.

11.6 Attorneys' Fees in the Event of Dispute. In the event any dispute between the parties hereto results in arbitration or litigation, the prevailing party shall be reimbursed for all reasonable costs, including, but not limited to, reasonable attorneys' fees.

11.7 Complete Agreement. This Agreement constitutes the complete and exclusive statement of the agreement among the Members. It supersedes all prior written and oral statements, including any prior representation, statement, condition, or warranty.

11.8 Applicable Law. All questions concerning the construction, validity, and interpretation of this Agreement and the performance of the obligations imposed by this Agreement shall be governed by the internal law, not the law of conflicts, of the State of New York.

11.9 Section Titles. The headings herein are inserted as a matter of convenience only, and do not define, limit, or describe the scope of this Agreement or the intent of the provisions hereof.

11.10 Binding Provisions. This Agreement is binding upon, and inures to the benefit of, the parties hereto and their respective heirs, executors, administrators, personal and legal representatives, successors, and permitted assigns.

11.11 Terms. Common nouns and pronouns shall be deemed to refer to the masculine, feminine, neuter, singular and plural, as the identity of the Person may in the context require.

11.12 Severability of Provisions. Each provision of this Agreement shall be considered separable; and if, for any reason, any provision or provisions herein are determined to be invalid and contrary to any existing or future law, such invalidity shall not impair the operation of or affect those portions of this Agreement which are valid. Furthermore, if any provision of this Agreement shall be adjudicated to be invalid, overbroad or unenforceable, the parties agree that the court making such determination shall have the power to delete, amend and/or reduce the

duration and/or scope of, the provision thus adjudicated to be invalid or unenforceable to the extent necessary for said provision to be adjudicated valid and enforceable, such deletion and/or reduction to apply only with respect to the operation of this Agreement in the particular jurisdiction in which such adjudication is made.

11.13 Amendment. This Agreement may be amended, altered or modified only by the affirmative vote of all of the Members; provided, however, that this Agreement may be amended by the Managers without any action of the Members in any of the following cases:

(a) Upon an advice by counsel, to the extent necessary to permit the allocations and distributions contained in this Agreement to be sustained under existing or future federal income tax laws and as otherwise provided in this Agreement;

(b) Exhibit A, listing the addresses and Percentages of the Members, may be modified from time to time by the Managers to reflect any admission of new Members, any change in the Members or in the Membership Interest of any Member which has been effected by Transfer, operation of the express terms of this Agreement, or other appropriate action, or to reflect any Member's change of address;

(c) to correct any clerical errors or omissions, provided that the Managers gives prior written notice of such amendment to the Members; or

(d) to delete or add or modify any provision required to be so deleted, added, or modified by the staff of the Securities and Exchange Commission, any other federal agency or any state "Blue Sky" Commissioner or similar official, when the deletion, addition, or modification is for the benefit or protection of the Members.

11.14 Construction. The parties hereto have jointly participated in the negotiation and drafting of this Agreement. In the event of an ambiguity or if a question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by all of the parties hereto and no presumptions or burdens of proof shall arise favoring any party by virtue of authorship of any of the provisions of this Agreement.

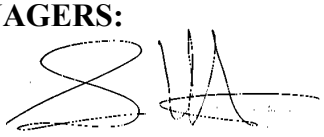
11.15 Counterparts. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original and all of which, when taken together, constitute one and the same document. The signature of any party to any counterpart shall be deemed a signature to, and may be appended to, any other counterpart.

11.16 Waiver. Gutnicki LLP ("**GLLP**") has acted as lead counsel in developing the documentation for the Company. In this regard, the parties to this Agreement acknowledge that GLLP has informed each Member that a conflict of interest exists in GLLP's representation in such formation and that each Member has been advised to seek outside counsel and business advice to review all documents relating to the Company, including without limitation this Agreement, and to advise each Member as to the effects, consequences and legalities of such documents.

Remainder of this page left intentionally blank. Signature page follows.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth above.

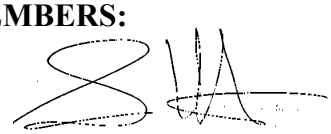
MANAGERS:



Sam Halper

Being the Managers of the Company

MEMBERS:



Sam Halper

David Gast

Ephram Lahasky

 {1171/001/00203081.1}

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth above.

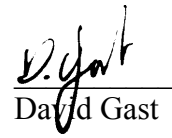
MANAGERS:

_____
Sam Halper

Being the Managers of the Company

MEMBERS:

_____
Sam Halper


_____
David Gast


_____

Ephram Lahasky

 {1171/001/00203081.1}

EXHIBIT A

MEMBERS AND CAPITAL

Member	Capital Contribution	Loan Amount	Percentage
Sam Halper	$		33.34%
David Gast	$		33.33%
Ephram Lahasky	$		33.33%

{1171/001/00203081.1}

EXHIBIT 9

CIBC

BUSINESS ENTITY ACCOUNT SIGNATURE CARD

DATE 02/09/2018	**Financial Institution Branch Address** 120 South LaSalle St Chicago, IL 60603 Opened By: Eugenia Spina

ACCOUNT INFORMATION

TITLE OF ACCOUNT Chms Group, LLC
Payroll Account

1800 Rockaway Ave Suite 200
Hewlett NY 11557-1668

ACCOUNT NUMBER [redacted]8819
ACCOUNT T.I.N [redacted]

PRODUCT NAME Business Checking ☐ Check box if the Account has a Beneficial Owner that is not the Entity

BUSINESS ENTITY INFORMATION (the "Entity")

Business Name and Address
Chms Group, LLC

1800 Rockaway Ave Suite 200
Hewett, NY 11557

Assumed Name if D/B/A

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is the correct taxpayer identification number for the Entity, (or I am waiting for a number to be issued to me). and
2. The Entity is not subject to backup withholding because: (a) it is exempt from backup withholding, or (b) it has not been notified by the Internal Revenue Service (IRS) that it is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified it that it is no longer subject to backup withholding, and
3. The Entity is a U.S. person.
4. The Entity is exempt from FATCA reporting.

You must cross out Item 2 above if the Entity has been notified by the IRS that it is currently subject to backup withholding because it failed to report all interest and dividends on its tax return.

SIGNATURE Efram Mordy Lahasky 2/16/18 DATE ☐ See separate W-9/W-8 Document

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT. To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.
What this means for you: When you open an account, we will ask you for your name, address, date of birth, and other information that will allow us to identify you and the Entity. We may also ask to see your driver's license or other identifying documents.

ACKNOWLEDGMENT. The Entity agrees to be bound by the rules and conditions of CIBC Bank USA ("Bank") that govern this account, as they may be amended, including the Business Deposit Account Agreement and Disclosure ("Agreement and Disclosure"). By signing this document, I/We acknowledge on behalf of the Entity that the Agreement and Disclosure has been received. I/We certify that all of the information printed on this signature card and that I/We provided to the Bank is true and accurate, including, without limitation, the names and titles of each of the individuals who have signed below. I/We agree that the Bank has the right to charge this account for any liabilities owed to the Bank by the Entity. All signors are acting on behalf of the Entity.

Any one signature required for Account actions. If this Signature Card relates to a Certificate of Deposit, the individuals that execute below and, if applicable, the attached addendum, shall be authorized to transact business under any account for renewals of such Certificate of Deposit.

☒ Check box if the Entity desires that the individuals that execute below, and if applicable, the attached addendum, be authorized to transact business under all accounts of the Entity with the Bank.

X _____ 2/16/18
Name: Michael Neufeld Date
Title: Authorized Signer

X _____ 2/16/18
Name: Sam Halper Date
Title: Managing member

X _____ 2/16/18
Name: David S Gast Date
Title: Managing member

X _____ 2/16/18
Name: Efram Mordy Lahasky Date
Title: Manager

EXHIBIT 10

CHASE

Business Signature Card

ACCOUNT TITLE ("DEPOSITOR")
CHMS GROUP LLC

BUSINESS ADDRESS
600 BROADWAY STE E

LYNBROOK, NY 11563-3980

ACCOUNT NUMBER [redacted]360
ACCOUNT TYPE Chase Platinum Business Checking
TAXPAYER ID NUMBER [redacted]
DATE OPENED 02/13/2015
FORM OF BUSINESS Limited Liability Company - Member Managed (LLC)
ISSUED BY JPMorgan Chase Bank, N.A (802)
Lawrence Rockaway - 207
RABIULLAH ASADI
(516) 371-4100
02/13/2015

PRIMARY ID TYPE	PRIMARY ID NUMBER	ISSUER	ISSUANCE DATE	EXPIRATION DATE
Website Documentation	[redacted]	NY	01/13/2015	
SECONDARY ID TYPE	**SECONDARY ID NUMBER**	**ISSUER**	**ISSUANCE DATE**	**EXPIRATION DATE**
None				

ACKNOWLEDGEMENT - By signing this Signature Card, the Depositor applies to open a deposit account at JPMorgan Chase Bank, N.A. (the "Bank"). The Depositor represents and warrants that (i) the signatures appearing below are genuine or facsimile signatures of the person(s) authorized to transact business and (ii) all necessary actions or formalities, where necessary, have been taken to authorize the named person(s) to so act. The Bank is entitled to rely on the authority of the named person(s) until written revocation of such authority is received by the Bank. The Depositor certifies that the information provided to the Bank is true to the best of its knowledge and authorizes the Bank, at its discretion, to obtain credit reports on the Depositor. The Depositor acknowledges receipt of the Bank's Deposit Account Agreement or other applicable account agreement, which include all provisions that apply to this deposit account, and other agreements and service terms for account analysis and other treasury management services if applicable, and agree to be bound by the terms and conditions contained therein as amended from time to time.

** When you give us your mobile phone number, we have your permission to contact you at that number about all your Chase or J.P. Morgan accounts. Your consent allows us to use text messaging, artificial or prerecorded voice messages and automatic dialing technology for informational and account service calls, but not for telemarketing or sales calls. It may include contact from companies working on our behalf to service your accounts. Message and data rates may apply. You may contact us anytime to change these preferences.

	PRINTED NAME	**TELEPHONE NUMBER	TAXPAYER ID #	TITLE	DATE	SIGNATURE
1)	SAM A HALPER	[redacted]	[redacted]	Member	02/13/2015	Refer to the Add Partner/Member/Manager Not Present
2)	DAVID GAST	[redacted]	[redacted]	Member	2/13/15	D. Gast
3)						
4)						

M1207-01-13-GS (3/14)

Scan

CHASE

ADD PARTNER/MEMBER/MANAGER
NOT PRESENT FORM - INDIVIDUAL

(A Chase banker must complete all fields on this form. This form will expire 30 days from the date the customer signed.)

Legal Business Name: CHMS GROUP LLC

State of Organization: NEW YORK

☐ PARTNER ■ MEMBER ☐ MANAGER — SIGNER: ■ Yes ☐ No

Name (First)	(Middle Initial)	(Last)	Tax ID No. (SSN or ITIN)
SAM	ABRAHAM	HALPER	[redacted]

Percentage of Ownership:	Date of Birth (mm/dd/yyyy)	Country of Citizenship:
50	[redacted]	US

Residential Street Address: [redacted]

City	State/Province	Country (If not USA)	ZIP Code
NEW YORK	NY		10028

Is the Partner/Member/Manager a current (active or reserve) or former member of the United States Military? ☐ Yes ■ No

Home Phone #	Cell Phone #	Work Phone #	Ext.	Fax #	International Phone #
	[redacted]				

ID Type	Issuer	ID Number (if any)	Issuance Date (if any)	Expiration Date (if any)
Primary ID Type: DRIVER LICENSE	NYS	[redacted]	01/07/0205	04/02/2016
Secondary ID Type: CREDIT CARD	AMERICAN EXPRES	[redacted]		[redacted]

Occupation:	Email Address:
SELF EMPLOYED	[redacted]

The individual signing this Form certifies to JPMorgan Chase Bank, N.A. (the "Bank") as follows:

- the Organization is a limited liability company or partnership, duly organized under the laws of the state of organization listed above;
- the individual signing this Form is a member (if managed by its members) ("Members") or manager (if managed by managers) ("Managers") or General Partner ("Partner") of the Organization; and
- the Organization has authorized all actions and agreements described in this Form in accordance with all requirements of law and of Organization's organizational documents and bylaws, if any, and the authorizations are now in full force and effect.

Account Opening and Contractual Authorization

By completing and signing this Form, any partner, member or manager acting alone, may:

- Open or close one or more accounts with the Bank at any time, subject to the Bank's deposit account agreement;
- Act on behalf of the Organization in any matter involving any of the Organization's depository accounts at the Bank;
- Sign all agreements or other documents relating to any depository accounts or other business of the organization. These agreements and other documents include but are not limited to funds transfer agreements, agreements for automated clearinghouse services, agreements for online services, and safe deposit agreements.

Deposit and Withdrawal Authorization

Each person authorized as a signer on the account(s) at account opening ("Authorized Person") may deposit or withdraw the Organization's funds. Each Authorized Person may sign any and all checks, drafts, and orders drawn against any account of the Organization at the Bank, and may give instructions for account transactions without a signature, such as those initiated via electronic debit, payment, wire transfer, or other withdrawal of funds by computer, electronic or other means. The Bank is authorized to pay any checks or other transactions authorized by the Organization, even if doing so causes or increases an overdraft. Each Authorized Person may endorse for cash, collection, deposit, or negotiation any checks, drafts, notes, bills of exchange, or certificates of deposit, and order the payment or transfer of money between accounts at the Bank and other banks. Endorsements "for deposit" may be written or stamped. The Bank may accept any instrument for deposit to any depository account of the Organization without endorsement or may supply the endorsement of the Organization. The Bank is authorized to pay all checks, drafts, and orders when signed, endorsed, or authorized by any Authorized Person without inquiry as to the circumstances of issue or disposition of the proceeds and regardless of to whom such instruments are payable or endorsed, including those payable to or endorsed to the Authorized Person.

Signature of Partner/Member/Manager: [signature] **Date Signed:** 7/2/15

Signature and identification verified by:

Banker Signature: [signature] Banker Name: Rahimullah Asadi

Standard ID: I534316

Bank Copy

M1211-01 (10/14)

JPMorgan Chase Bank, N.A. Member FDIC

Scan

CHASE

Business Signature Card

ACCOUNT TITLE ("DEPOSITOR")
CHMS GROUP LLC

BUSINESS ADDRESS
600 BROADWAY STE E

LYNBROOK, NY 11563-3980

ACCOUNT NUMBER [redacted]360
ACCOUNT TYPE Chase Platinum Business Checking
TAXPAYER ID NUMBER [redacted]
DATE OPENED 02/13/2015
FORM OF BUSINESS Limited Liability Company - Member Managed (LLC)
ISSUED BY JPMorgan Chase Bank, N.A (802)
Lawrence Rockaway - 207
RABIULLAH ASADI
(516) 371-4100
02/13/2015

PRIMARY ID TYPE	PRIMARY ID NUMBER	ISSUER	ISSUANCE DATE	EXPIRATION DATE
Website Documentation	[redacted]	NY	01/13/2015	
SECONDARY ID TYPE	**SECONDARY ID NUMBER**	**ISSUER**	**ISSUANCE DATE**	**EXPIRATION DATE**
None				

ACKNOWLEDGEMENT - By signing this Signature Card, the Depositor applies to open a deposit account at JPMorgan Chase Bank, N.A. (the "Bank"). The Depositor represents and warrants that (i) the signatures appearing below are genuine or facsimile signatures of the person(s) authorized to transact business and (ii) all necessary actions or formalities, where necessary, have been taken to authorize the named person(s) to so act. The Bank is entitled to rely on the authority of the named person(s) until written revocation of such authority is received by the Bank. The Depositor certifies that the information provided to the Bank is true to the best of its knowledge and authorizes the Bank, at its discretion, to obtain credit reports on the Depositor. The Depositor acknowledges receipt of the Bank's Deposit Account Agreement or other applicable account agreement, which include all provisions that apply to this deposit account, and other agreements and service terms for account analysis and other treasury management services if applicable, and agree to be bound by the terms and conditions contained therein as amended from time to time.

** When you give us your mobile phone number, we have your permission to contact you at that number about all your Chase or J.P. Morgan accounts. Your consent allows us to use text messaging, artificial or prerecorded voice messages and automatic dialing technology for informational and account service calls, but not for telemarketing or sales calls. It may include contact from companies working on our behalf to service your accounts. Message and data rates may apply. You may contact us anytime to change these preferences.

	PRINTED NAME	**TELEPHONE NUMBER	TAXPAYER ID #	TITLE	DATE	SIGNATURE
1)	SAM A HALPER	[redacted]	[redacted]	Member	02/13/2015	Refer to the Add Partner/Member/Manager Not Present
2)	DAVID GAST	[redacted]	[redacted]	Member	2/13/15	D. Gast
3)						
4)						

M1207-01-13-CS (3/14)

Scan

CHASE

ADD PARTNER/MEMBER/MANAGER
NOT PRESENT FORM - INDIVIDUAL

(A Chase banker must complete all fields on this form. This form will expire 30 days from the date the customer signed.)

Legal Business Name: CHMS GROUP LLC

State of Organization: NEW YORK

☐ PARTNER ■ MEMBER ☐ MANAGER SIGNER: ■ Yes ☐ No

Name (First)	(Middle Initial)	(Last)	Tax ID No. (SSN or ITIN)
SAM	ABRAHAM	HALPER	[redacted]

Percentage of Ownership:	Date of Birth (mm/dd/yyyy)	Country of Citizenship:
50	[redacted]	US

Residential Street Address: [redacted]

City	State/Province	Country (if not USA)	ZIP Code
NEW YORK	NY		10028

Is the Partner/Member/Manager a current (active or reserve) or former member of the United States Military? ☐ Yes ■ No

Home Phone #	Cell Phone #	Work Phone # Ext.	Fax #	International Phone #
	[redacted]			

Primary ID Type:	Issuer:	ID Number (if any):	Issuance Date (if any):	Expiration Date (if any):
DRIVER LICENSE	NYS	[redacted]	01/07/0205	04/02/2016
Secondary ID Type:	**Issuer:**	**ID Number (if any):**	**Issuance Date (if any):**	**Expiration Date (if any):**
CREDIT CARD	AMERICAN EXPRES	[redacted]		[redacted]

Occupation: SELF EMPLOYED

Email Address: [redacted]

The individual signing this Form certifies to JPMorgan Chase Bank, N.A. (the "Bank") as follows:

- the Organization is a limited liability company or partnership, duly organized under the laws of the state of organization listed above;
- the individual signing this Form is a member (if managed by its members) ("Members") or manager (if managed by managers) ("Managers") or General Partner ("Partner") of the Organization; and
- the Organization has authorized all actions and agreements described in this Form in accordance with all requirements of law and of Organization's organizational documents and bylaws, if any, and the authorizations are now in full force and effect.

Account Opening and Contractual Authorization

By completing and signing this Form, any partner, member or manager acting alone, may:

- Open or close one or more accounts with the Bank at any time, subject to the Bank's deposit account agreement;
- Act on behalf of the Organization in any matter involving any of the Organization's depository accounts at the Bank;
- Sign all agreements or other documents relating to any depository accounts or other business of the organization. These agreements and other documents include but are not limited to funds transfer agreements, agreements for automated clearinghouse services, agreements for online services, and safe deposit agreements.

Deposit and Withdrawal Authorization

Each person authorized as a signer on the account(s) at account opening ("Authorized Person") may deposit or withdraw the Organization's funds. Each Authorized Person may sign any and all checks, drafts, and orders drawn against any account of the Organization at the Bank, and may give instructions for account transactions without a signature, such as those initiated via electronic debit, payment, wire transfer, or other withdrawal of funds by computer, electronic or other means. The Bank is authorized to pay any checks or other transactions authorized by the Organization, even if doing so causes or increases an overdraft. Each Authorized Person may endorse for cash, collection, deposit, or negotiation any checks, drafts, notes, bills of exchange, or certificates of deposit, and order the payment or transfer of money between accounts at the Bank and other banks. Endorsements "for deposit" may be written or stamped. The Bank may accept any instrument for deposit to any depository account of the Organization without endorsement or may supply the endorsement of the Organization. The Bank is authorized to pay all checks, drafts, and orders when signed, endorsed, or authorized by any Authorized Person without inquiry as to the circumstances of issue or disposition of the proceeds and regardless of to whom such instruments are payable or endorsed, including those payable to or endorsed to the Authorized Person.

Signature of Partner/Member/Manager: [signature] **Date Signed:** 7/2/15

Signature and identification verified by:

Banker Signature: [signature] Banker Name: Rabiul Hoq Asadi

Standard ID: I534316

Bank Copy

M1211-01 (10/14) JPMorgan Chase Bank, N.A. Member FDIC

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CHASE

BUSINESS ACCOUNT ADD SIGNERS FORM

NAME OF BUSINESS CHMS GROUP LLC

TAXPAYER ID NO. [redacted]

BUSINESS ADDRESS 600 BROADWAY STE E, LYNBROOK, NY 11563-3980

BRANCH NAME AND NO. HEWLETT AND PENINSULA - 3821 BANK NO. 802 BRANCH PHONE NO. (516) 569-0441

INTEROFFICE MAILCODE NY2-3821 PREPARED BY: NAME AMIT CHAWLA DATE: 02/26/2015

Please add the following signer to the accounts listed below (other authorized signers on record do not change):

Name of the Signer to Add	Title	Signature	Date
MR MICHAEL NEUFELD	SIGNER		2/26/15

Identification	ID Number	Issuer	Issuance Date	Expiration Date
1) Driver's License 2) None	[redacted]	NY	11/18/2013	11/19/2021

Account Numbers: [redacted]

Please add the following signer to the accounts listed below (other authorized signers on record do not change):

Name of the Signer to Add	Title	Signature	Date

Identification	ID Number	Issuer	Issuance Date	Expiration Date

Account Numbers:

Please add the following signer to the accounts listed below (other authorized signers on record do not change):

Name of the Signer to Add	Title	Signature	Date

Identification	ID Number	Issuer	Issuance Date	Expiration Date

Account Numbers:

CERTIFICATION

The undersigned hereby certifies that the person(s) added as authorized signers on the account(s) indicated above have been added in accordance with resolutions or other documents of the Business regarding signing authority for bank accounts. The undersigned further certifies that for those added as authorized signers, the names, titles and signatures are correct.

For a Corporation or Unincorporated Association or Organization:		For Sole Proprietorship:		For Partnership or Limited Liability Company:		For Government Entity:	
Secretary	Date	Owner/Sole Proprietor	Date	Partner/Member/Manager	Date	Certifying Official	Date

CHASE

BUSINESS ACCOUNT ADD SIGNERS FORM

NAME OF BUSINESS CHMS GROUP LLC

TAXPAYER ID NO. [redacted]

BUSINESS ADDRESS 600 BROADWAY STE E, LYNBROOK, NY 11563-3980

BRANCH NAME AND NO. HEWLETT AND PENINSULA - 3821 BANK NO. 802 BRANCH PHONE NO. (516) 569-0441

INTEROFFICE MAILCODE NY2-3821 PREPARED BY: NAME AMIT CHAWLA DATE: 02/26/2015

Please add the following signer to the accounts listed below (other authorized signers on record do not change).

Name of the Signer to Add	Title	Signature	Date
MR MICHAEL NEUFELD	SIGNER		2/26/15

Identification	ID Number	Issuer	Issuance Date	Expiration Date
1) Driver's License 2) None	[redacted]	NY	11/18/2013	11/19/2021

Account Numbers: [redacted]

Please add the following signer to the accounts listed below (other authorized signers on record do not change).

Name of the Signer to Add	Title	Signature	Date

Identification	ID Number	Issuer	Issuance Date	Expiration Date

Account Numbers:

Please add the following signer to the accounts listed below (other authorized signers on record do not change).

Name of the Signer to Add	Title	Signature	Date

Identification	ID Number	Issuer	Issuance Date	Expiration Date

Account Numbers:

CERTIFICATION

The undersigned hereby certifies that the person(s) added as authorized signers on the account(s) indicated above have been added in accordance with resolutions or other documents of the Business regarding signing authority for bank accounts. The undersigned further certifies that for those added as authorized signers, the names, titles and signatures are correct.

For a Corporation or Unincorporated Association or Organization:		For Sole Proprietorship:		For Partnership or Limited Liability Company:		For Government Entity:	
Secretary	Date	Owner/Sole Proprietor	Date	Partner/Member/Manager	Date	Certifying Official	Date

CHASE

BUSINESS ACCOUNT ADD SIGNERS FORM

NAME OF BUSINESS CHMS GROUP LLC

TAXPAYER ID NO. [redacted]

BUSINESS ADDRESS 600 BROADWAY STE E, LYNBROOK, NY 11563-3980

BRANCH NAME AND NO. LAWRENCE ROCKAWAY - 207 BANK NO. 802 BRANCH PHONE NO. (516) 371-4100

INTEROFFICE MAILCODE NY2-0207 PREPARED BY: NAME RABIULLAH ASADI DATE: 02/27/2015

Please add the following signer to the accounts listed below (other authorized signers on record do not change):

Name of the Signer to Add	Title	Signature	Date
EPHRAM M LAHASKY	SIGNER		2/27/15

Identification	ID Number	Issuer	Issuance Date	Expiration Date
1) Driver's License 2) None	[redacted]	NY	11/14/2014	01/19/2020

Account Numbers: [redacted]

Please add the following signer to the accounts listed below (other authorized signers on record do not change):

Name of the Signer to Add	Title	Signature	Date

Identification	ID Number	Issuer	Issuance Date	Expiration Date

Account Numbers:

Please add the following signer to the accounts listed below (other authorized signers on record do not change):

Name of the Signer to Add	Title	Signature	Date

Identification	ID Number	Issuer	Issuance Date	Expiration Date

Account Numbers:

CERTIFICATION

The undersigned hereby certifies that the person(s) added as authorized signers on the account(s) indicated above have been added in accordance with resolutions or other documents of the Business regarding signing authority for bank accounts. The undersigned further certifies that for those added as authorized signers, the names, titles and signatures are correct.

For a Corporation or Unincorporated Association or Organization:		For Sole Proprietorship:		For Partnership or Limited Liability Company:		For Government Entity:	
Secretary	Date	Owner/Sole Proprietor	Date	Partner/Member/Manager	Date	Certifying Official	Date

EXHIBIT 11

CHASE

Business Signature Card

ACCOUNT TITLE ("DEPOSITOR")
VILLAGES OF ORLEANS LLC

BUSINESS ADDRESS
14012 STATE HWY 31 1

ALBION, NY 14411

ACCOUNT NUMBER [redacted]691
ACCOUNT TYPE Chase Platinum Business Checking
TAXPAYER ID NUMBER [redacted]
DATE OPENED 08/26/2015
FORM OF BUSINESS Limited Liability Company - Member Managed (LLC)
ISSUED BY JPMorgan Chase Bank, N.A (802)
Cedarhurst - 998
ALAN FASS
[redacted]
08/26/2015

PRIMARY ID TYPE	PRIMARY ID NUMBER	ISSUER	ISSUANCE DATE	EXPIRATION DATE
Website Documentation	[redacted]	NY	03/09/2015	
SECONDARY ID TYPE	**SECONDARY ID NUMBER**	**ISSUER**	**ISSUANCE DATE**	**EXPIRATION DATE**
None				

ACKNOWLEDGEMENT - By signing this Signature Card, the Depositor applies to open a deposit account at JPMorgan Chase Bank, N.A. (the "Bank"). The Depositor represents and warrants that (i) the signatures appearing below are genuine or facsimile signatures of the person(s) authorized to transact business and (ii) all necessary actions or formalities, where necessary, have been taken to authorize the named person(s) to so act. The Bank is entitled to rely on the authority of the named person(s) until written revocation of such authority is received by the Bank. The Depositor certifies that the information provided to the Bank is true to the best of its knowledge and authorizes the Bank, at its discretion, to obtain credit reports on the Depositor. The Depositor acknowledges receipt of the Bank's Deposit Account Agreement or other applicable account agreement, which include all provisions that apply to this deposit account, and other agreements and service terms for account analysis and other treasury management services if applicable, and agree to be bound by the terms and conditions contained therein as amended from time to time.

** When you give us your mobile phone number, we have your permission to contact you at that number about all your Chase or J.P. Morgan accounts. Your consent allows us to use text messaging, artificial or prerecorded voice messages and automatic dialing technology for informational and account service calls, but not for telemarketing or sales calls. It may include contact from companies working on our behalf to service your accounts. Message and data rates may apply. You may contact us anytime to change these preferences.

	PRINTED NAME	**TELEPHONE NUMBER	TAXPAYER ID #	TITLE	DATE	SIGNATURE
1)	DAVID GAST	[redacted]	[redacted]	Member	8/26/15	DGast
2)						
3)						
4)						

M1207-01-15-CS (3/14 v2)

Scan

EXHIBIT 12

BUSINESS DEPOSITORY CERTIFICATE (Limited Liability Company)

CHASE

__X__NEW _____CHANGE

ACCOUNT NO.
2691

ACCOUNT TITLE
VILLAGES OF ORLEANS LLC

BUSINESS ADDRESS
14012 STATE HWY 31 1

ALBION, NY 14411

BANK NAME/NUMBER
JPMorgan Chase Bank, N.A (802)

BRANCH NAME AND NO.
Cedarhurst - 998

DATE
08/26/2015

PREPARED BY
ALAN FASS

PHONE NO.

PRODUCT TYPE
Chase Platinum Business Checking

Legal Name of Organization: VILLAGES OF ORLEANS LLC (the "Organization")

State of Organization: NY

Type of Organization (check one):
[X] Limited liability company managed by its members
[ ] Limited liability company managed by one or more managers

The individuals signing this Certificate certify to JPMorgan Chase Bank, N.A. (the "Bank") as follows:

- the Organization is a limited liability company, duly organized under the laws of the state of organization listed above;
- the individuals signing this Certificate are, or are authorized representatives of, all of the members (if managed by its members) ("Members") or managers (if managed by managers) ("Managers") of the Organization; and
- the Organization has authorized all actions and agreements described in this Certificate in accordance with all requirements of law and of Organization's organizational documents and bylaws, if any, and the authorizations are now in full force and effect.

Account Opening and Contractual Authorization
Any of the people listed below ("Authorized Persons"), acting alone, may:

- Open or close one or more accounts with the Bank at any time, subject to the Bank's deposit account agreement;
- Act on behalf of the Organization in any matter involving any of the Organization's depository accounts at the Bank;
- Sign all agreements or other documents relating to any depository accounts or other business of the Organization. These agreements & other documents include but are not limited to funds transfer agreements, agreements for automated clearinghouse services, agreements for online services, and safe deposit agreements.

Deposit and Withdrawal Authorization
Each Authorized Person may deposit or withdraw the Organization's funds. Each Authorized Person may sign any and all checks, drafts, and orders drawn against any account of the Organization at the Bank, and may give instructions for account transactions without a signature, such as those initiated via electronic debit, payment, wire transfer, or other withdrawal of funds by computer, electronic or other means. The Bank is authorized to pay any checks or other transactions authorized by the Organization, even if doing so causes or increases an overdraft. Each Authorized Person may endorse for cash, collection, deposit, or negotiation any checks, drafts, notes, bills of exchange, or certificates of deposit, and order the payment or transfer of money between accounts at the Bank and other banks. Endorsements "for deposit" may be written or stamped. The Bank may accept any instrument for deposit to any depository account of the Organization without endorsement or may supply the endorsement of the Organization. The Bank is authorized to pay all checks, drafts, and orders when signed, endorsed, or authorized by any Authorized Person without inquiry as to the circumstances of issue or disposition of the proceeds and regardless of to whom such instruments are payable or endorsed, including those payable to or endorsed to the Authorized Person.

Print Name	Title	Facsimile Signatures
DAVID GAST	Member	

SIGNER(S) TO BE ADDED LATER

Facsimile Signature Authorization
The Bank is authorized and directed to pay checks bearing any form of facsimile or computer-generated signature. If the Organization either uses or provides a signature card authorizing any facsimile or computer-generated signature, the Organization will be solely responsible for any check bearing a similar signature.

Further Authorizations
Each Member or Manager, as applicable, acting alone, is authorized to certify to the Bank the name, title, specimen signature and facsimile signature of any additional Authorized Person, or to instruct the Bank to remove any Authorized Person. The Bank may rely on this Certificate until it receives express written notice of a change or revocation.

FOR THE PRECEDING PURPOSES, each of the undersigned has signed his/her name(s) on the date indicated above.

Exemption from FATCA reporting code (if any) _____ [According to the IRS Form W-9 instructions, if you are only submitting this form for an account you hold in the United States, you may leave this field blank.]

CERTIFICATION
The undersigned certifies under penalties of perjury that (1) the Organization's Taxpayer Identification Number shown above is correct, and (2) the Organization is not subject to backup withholding because: (a) the Organization is exempt from backup withholding, or (b) the Organization has not been notified by the Internal Revenue Service (IRS) that it is subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the Organization that it is no longer subject to backup withholding, and (3) the Organization is a U.S. citizen or other U.S. person (as defined in the Form W-9 Instructions), and (4) the FATCA code(s) entered on this form (if any) indicating that the Organization is exempt from FATCA reporting is correct.

If the IRS has notified the Organization that it is subject to backup withholding due to underreporting interest or dividends on its tax return, cross out item 2 above.

CHASE

BUSINESS DEPOSITORY CERTIFICATE
(Limited Liability Company)

ACCOUNT NO. 2691

Note: For a disregarded entity, if the owner is not signing below, he, she or it must submit IRS Form W-9 or the appropriate Form W-8.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Member or Manager _____ Date 5/06/15

Printed Name: DAVID GAST

Member or Manager _____ Date _____

Printed Name: _____

Member or Manager _____ Date _____

Printed Name: _____

Member or Manager _____ Date _____

Printed Name: _____

Member or Manager _____ Date _____

Printed Name: _____

Member or Manager _____ Date _____

Printed Name: _____

Member or Manager _____ Date _____

Printed Name: _____

Member or Manager _____ Date _____

Printed Name: _____

(Attach additional pages if necessary to reflect all Members or Managers)

DISTRIBUTION: 1) National Account Services 2) Customer

M1207-04-CS (5/14)

JPMorgan Chase Bank, N.A. Member FDIC

EXHIBIT 13

Department of State
Division of Corporations

Entity Information

Return to Results | Return to Search

Entity Details

ENTITY NAME: VILLAGES OF ORLEANS LLC
DOS ID: 4722409
FOREIGN LEGAL NAME:
FICTITIOUS NAME:
ENTITY TYPE: DOMESTIC LIMITED LIABILITY COMPANY
DURATION DATE/LATEST DATE OF DISSOLUTION:
SECTIONOF LAW: 203 LLC - LIMITED LIABILITY COMPANY LAW
ENTITY STATUS: ACTIVE
DATE OF INITIAL DOS FILING: 03/09/2015
REASON FOR STATUS:
EFFECTIVE DATE INITIAL FILING: 03/09/2015
INACTIVE DATE:
FOREIGN FORMATION DATE:
STATEMENT STATUS: CURRENT
COUNTY: NASSAU
NEXT STATEMENT DUE DATE: 03/31/2023
JURISDICTION: NEW YORK, UNITED STATES
NFP CATEGORY:

ENTITY DISPLAY | NAME HISTORY | FILING HISTORY | MERGER HISTORY | ASSUMED NAME HISTORY

Service of Process Name and Address

Name: DAVID GAST

Address: 1800 ROCKAWAY AVENUE, 2ND FLOOR SUITE 200, LAWRENCE, NY, UNITED STATES, 11559

Chief Executive Officer's Name and Address

Name:

Address:

Principal Executive Office Address

Address:

Registered Agent Name and Address

Name:

Address:

Entity Primary Location Name and Address

Name:

Address:

Farmcorpflag

Is The Entity A Farm Corporation: NO

Stock Information

Share Value	Number Of Shares	Value Per Share

EXHIBIT 14

CHASE

Business Signature Card

ACCOUNT TITLE ("DEPOSITOR")
ML KIDS HOLDING LLC

BUSINESS ADDRESS
34 LORD AVE

LAWRENCE, NY 11559-1324

ACCOUNT NUMBER [redacted]890
ACCOUNT TYPE Chase Platinum Business Checking
TAXPAYER ID NUMBER [redacted]
DATE OPENED 10/26/2018
FORM OF BUSINESS Limited Liability Company - Member Managed (LLC)
ISSUED BY JPMorgan Chase Bank, N.A (802)
Huntington - 891
GEORGE E FRENZEL III
(631) 673-7411
10/26/2018

PRIMARY ID TYPE	PRIMARY ID NUMBER	ISSUER	ISSUANCE DATE	EXPIRATION DATE
Articles of Organization	[redacted]	Delaware	03/13/2018	
SECONDARY ID TYPE	**SECONDARY ID NUMBER**	**ISSUER**	**ISSUANCE DATE**	**EXPIRATION DATE**
None				

ACKNOWLEDGEMENT - By signing this Signature Card, the Depositor applies to open a deposit account at JPMorgan Chase Bank, N.A. (the "Bank"). The Depositor represents and warrants that (i) the signatures appearing below are genuine or facsimile signatures of the person(s) authorized to transact business and (ii) all necessary actions or formalities, where necessary, have been taken to authorize the named person(s) to so act. The Bank is entitled to rely on the authority of the named person(s) until written revocation of such authority is received by the Bank. The Depositor certifies that the information provided to the Bank is true to the best of its knowledge and authorizes the Bank, at its discretion, to obtain credit reports on the Depositor. The Depositor acknowledges receipt of the Bank's Deposit Account Agreement or other applicable account agreement, which include all provisions that apply to this deposit account, and other agreements and service terms for account analysis and other treasury management services if applicable, and agree to be bound by the terms and conditions contained therein as amended from time to time.

** When you give us your mobile phone number, we have your permission to contact you at that number about all your Chase or J.P. Morgan accounts. Your consent allows us to use text messaging, artificial or prerecorded voice messages and automatic dialing technology for informational and account service calls, but not for telemarketing or sales calls. It may include contact from companies working on our behalf to service your accounts. Message and data rates may apply. You may contact us anytime to change these preferences.

	PRINTED NAME	**TELEPHONE NUMBER	TAXPAYER ID #	TITLE	DATE	SIGNATURE
1)	EFRAIM M LAHASKY		[redacted]	Member	10/26/2018	
2)						
3)						
4)						

EXHIBIT 15

OPERATING AGREEMENT OF
COMPREHENSIVE AT ORLEANS LLC

This Operating Agreement made this 3RD day of March 2014 (the "Agreement") of Comprehensive at Orleans LLC is entered into by Bernard Fuchs, with an address of [redacted] Fuchs"), (Fuchs is referred to herein as the "Members" or as a "Member").

WITNESSETH:

WHEREAS, the Members have formed a New York limited liability company known as Comprehensive at Orleans LLC (the "Company") for the purposes and on the terms and conditions set forth in this Agreement; and

WHEREAS, the Members wish to create an Operating Agreement to establish the rules and procedures that are to govern the conduct of the business and affairs of the Company and related business and affairs and which shall supersede all prior Operating Agreements.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants hereinafter set forth, the Members, intending to be legally bound, hereby mutually covenant and agree as follows:

ARTICLE ONE

Definitions

The capitalized terms used in this Agreement shall have the meanings specified in this Article One.

"Act" shall mean the Limited Liability Company Law of the Consolidated Laws of New York, Section 203, *et seq.*, as it may be amended from time to time, and any successor to said Statute.

"Adjusted Capital Account Deficit" shall have the meaning set forth in Section 6.2.1.

"Affiliate" shall mean with respect to any Member (a) any Person that, directly or indirectly, controls, is controlled by or is under common control with such Member and (b)any spouse, parent or issue of any Member. For these purposes, control means the possession, directly or indirectly, of the power to direct or cause the direction of the management of any Person whether through the ownership of voting securities, by contract or otherwise.

"Articles of Organization" shall mean the Company's Articles of Organization as filed with the Secretary of State, as they may be amended, supplemented or restated from time to time.

"Bankruptcy" shall mean, with respect to a Person, the occurrence of any of the following events: (a) the filing by that Person of a petition commencing a voluntary case in bankruptcy under applicable bankruptcy laws; (b) the entry against that Person of an order for relief under applicable bankruptcy laws; (c) the written admission by that Person of his or her inability to pay his or her debts as they mature, or an assignment by that Person for the benefit of creditors; (d) the appointment of a receiver for the property or affairs of that Person; or (e) the institution of any proceeding against such Person seeking to adjudicate that he or she is bankrupt or insolvent or the imposition of any other remedy afforded under applicable bankruptcy laws, and either such proceeding shall remain undismissed or unstayed for a period of 30 days or any of the actions sought in such proceeding shall occur.

"Capital Account" shall have the meaning set forth in Section 3.3.

"Capital Contributions" shall mean the services and the amount of cash and the fair market value of any property (other than cash) that a Member contributes or is deemed to have contributed to the Company pursuant to Section 3.1.1.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time, and any corresponding provisions of any succeeding law.

"Company" shall have the meaning set forth in Section 2.2.

"Depreciation" shall mean, with respect to each fiscal year or other period, an amount equal to the depreciation, amortization or other cost recovery deduction allowable with respect to a Company asset for such year or other period, except that, if the Gross Asset Value of an asset differs from its adjusted basis for Federal income tax purposes at the beginning of such year or other period, Depreciation shall be an amount that bears the same ratio to such beginning Gross Asset Value as the Federal income tax depreciation, amortization or other cost recovery deduction for such year or other period bears to such beginning adjusted tax basis; provided, however, that if the Federal income tax depreciation, amortization, or other cost recovery deduction for such asset for such year or other period is zero, Depreciation shall be determined with reference to such beginning Gross Asset Value using any reasonable method selected by the Tax Matters Member.

"Excluded Acts of the Members" shall have the meaning set forth in Section 2.7.3.

"Gross Asset Value" shall mean the carrying values of each item of Company property, as reflected in the Company's books and records maintained for Code Section 704(b) purposes in accordance with Regulations §1.704-1(b), as reduced by Depreciation with respect to such item.

"Members" shall have the meaning set forth in the preamble to this Agreement.

"Membership Interests" shall have the meaning set forth in Section 2.6.1.

"Net Income" or "Net Loss" shall mean, with respect to each fiscal year or other period, an amount equal to the Company's Taxable Income or Tax Loss, as the case may be, for such fiscal year or other period, together with the following adjustments:

(a) any income of the Company that is exempt from federal income tax and not otherwise taken into account in computing Net Income or Net Loss pursuant to this definition shall be added to such Taxable Income or Tax Loss;

(b) any expenditures of the Company described in Code Section 705(a)(2)(B) or treated as Code Section 705(a)(2)(B) expenditures pursuant to Regulation § 1.704-1(b)(2)(iv)(i) and not otherwise taken into account in computing Net Income or Net Loss pursuant to this definition shall be subtracted from such Taxable Income or Tax Loss; and

(c) with respect to each asset whose Gross Asset Value differs from its adjusted Federal income tax basis, (1) in lieu of the depreciation, amortization, and other cost recovery deductions taken into account in computing such Taxable Income or Tax Loss, there shall be taken into account Depreciation for such fiscal year or other period, and (2) gain or loss resulting from any disposition of such asset shall be computed by reference to its Gross Asset Value, rather than the adjusted Federal income tax basis of such asset.

"Offer Notice" shall have the meaning set forth in Section 7.2(a).

"Offered Membership Interest" shall have the meaning set forth in Section 7.2.

"Offerees" shall have the meaning set forth in Section 7.2(a).

"Offeror" shall have the meaning set forth in Section 7.2.

"Person" shall mean any individual, partnership, corporation, Limited Liability Company, unincorporated organization or association, trust or other entity.

"Permitted Acts of the Members" shall have the meaning set forth in Section 2.7.3.

"Proposed Purchaser" shall have the meaning set forth in Section 7.2.

"Regulations" shall mean the Income Tax Regulations promulgated under the Code, as amended from time to time and any corresponding provisions of any succeeding regulations.

"Secretary of State" shall mean the New York Secretary of State.

"Tag Along Notice" shall have the meaning set forth in Section 7.2(d).

"Taxable Income" or "Tax Loss" shall mean, with respect to each fiscal year or other period, an amount equal to the Company's taxable income or loss for such fiscal year or other period determined in accordance with Code Section 703(a) (for this purpose, all items of income, gain, loss or deduction required to be separately stated pursuant to Code Section 703(a)(1) shall be included in such taxable income or loss).

"Tax Matters Member" shall have the meaning set forth in Section 10.6.

"Transfer" shall mean any sale, transfer, gift, assignment, pledge or grant of a security interest, by operation of law or otherwise, in or of an interest in the Company or of rights under this Agreement, excluding, however, any grant of such a security interest in favor of the Company.

ARTICLE TWO

Organization

2.1 **Formation.** The Members hereby ratify and approve all actions taken by them in connection with the organization of a limited liability company (the "Company"), including the filing of the Articles of Organization attached hereto as Exhibit A on February 3, 2014 pursuant to the provisions of the Act and this Agreement.

2.2 **Name**. The name of the Company is "Comprehensive at Orleans LLC"

2.3 **Purposes**. The purposes for which the Company is formed is limited to owning, operating and/or leasing the real and personal property of the nursing home facility currently doing business as The Villages of Orleans Health and Rehabilitation Center in the State of New York (the "Facility") located at 14012 Route 31 West, Albion, NY and engaging in all other activities and transactions as are incidental and necessary to the foregoing.

2.4 **Principal Office.** The location of the principal office of the Company shall be located at 14012 Route 31 West, Albion, NY in the County of Orleans, New York.

2.5 **Duration**. The term of the Company shall commence on the date that the Articles of Organization are filed with the Secretary of State and shall continue in full force and effect until terminated in accordance with the provisions of this Agreement.

2.6 **Members and Membership Interests.**

2.6.1 The Members of the Company and their percentage membership interests (the "Membership Interests") are as follows:

Name	Membership Interest
Fuchs	100%

A Member's Membership Interest is his aggregate rights in the Company, including, without limitation, his right to his interest in the Company's assets, liabilities, profits, losses and capital, his right to receive distributions from the Company and his right to vote and participate in the management of the Company.

2.6.2 Additional Members may be admitted into the Company as provided for under Article Seven. Unless named in this Agreement, or unless admitted to the Company as a substituted or new Member as provided herein, no Person shall be considered a Member, and the Company need deal only with the Members so named and so admitted. The Company shall not be required to deal with any other Person by reason of an assignment by a Member or by reason of the dissolution, death or bankruptcy of a Member, except as otherwise provided in this Agreement.

2.6.3 The Members agree that they shall refrain from taking or causing the Company to take any of the following types of action without the prior written consent of Members owning at least 66⅔% of the Membership Interest:

(a) issue or dispose of any Membership Interest or admit any Person as a Member (except as permitted herein);

(b) create, assume or suffer to exist any material mortgage, pledge or other encumbrance upon the Company's properties or assets now owned or hereafter acquired, except in the ordinary course of business;

(c) purchase or acquire, except in the ordinary course of business, any property or assets or obligations or stock of or interest in, make any capital contribution to, or otherwise invest directly or indirectly in, or make loans or advances to, any Member or Person;

(d) amend or change the Company's Articles of Organization, dissolve, create any subsidiary or merge or consolidate with or into any other company or corporation, except in the ordinary course of business;

(e) sell, lease, transfer or otherwise dispose of any of the Company's material assets or properties, except in the ordinary course of business; or

(f) make any material change in the character of the Company's business.

A Member shall not have voting rights hereunder in the event that he is in material violation of this Agreement and fails to cure such violation promptly after receiving notice thereof.

2.7 **Management.**

2.7.1 The corporate business obligations and tax, accounting, financial and other affairs of the Company shall be managed by the Members. The Members hereby designate Fuchs as the initial Chief Executive Officer and Secretary, and shall have such powers as are usually exercised by such designated officers of a New York corporation and shall have the authority to bind the Company through the exercise of such powers subject to, and to the extent consistent with, the terms hereof. The Members have the power and authority to delegate to one or more other persons the Member's rights and powers to manage and control the business and affairs of the Company, including the power and authority to delegate to agents, boards of managers, managing members or directors, officers and assistant officers, and employees of a Member of the Company, and the power and authority to delegate by a management agreement or another agreement with, or otherwise, to other persons. The Members initially delegate to the Facility administrator the power and responsibility for day to day operations of the Facility with power to bind the Company. The Members shall also from time to time appoint a "Governing Body" required by Federal Law to perform such duties as are federally mandated and may hire consultants to advise the Facility administrator on issues relating to day to day operations and/or financial reporting. Neither the management structure nor the provisions setting forth such structure may be deleted, modified or amended without the prior approval of the New York State Department of Health.

2.7.2 The Members shall be entitled to and shall be reimbursed by the Company for all out-of-pocket expenses incurred by the Members on behalf of the Company. Any such fees and/or reimbursements shall be treated as expenses of the Company and shall not be deemed to constitute distributions to the recipient of any profit, loss or capital of the Company.

2.7.3 No Member shall be liable, responsible, or accountable in damages or otherwise to the Company or any of its other Members for any failure to take any action or the taking of any action within the scope of authority conferred on him by this Agreement and made in good faith ("Permitted Acts of the Members"). Each Member shall be liable, responsible, and accountable in damages to the Company and the other Members for any acts performed by such Member arising out of or resulting from his fraud, criminal action or bad faith or the failure of such Member to comply in any material respect with any covenant, condition or other agreement of the Members contained herein ("Excluded Acts of the Members"). Nothing in this paragraph shall be deemed to make any of the Members liable, responsible or accountable to persons other than the Company or the Members.

2.7.4 The Members do not in any way guarantee the return of any Member's contribution or a profit for the Members from the Company's business.

2.7.5 The Members shall be entitled to indemnity from the Company on account of any claim, liability, action or damage arising from or relating to any Permitted Acts of the Members and on account of all reasonable attorney's fees and disbursements incurred in connection therewith. The Members shall not be entitled to indemnity from the Company on account of any claim, liability, action or damage arising from or relating to any Excluded Acts of the Members.

ARTICLE THREE

Capital Contributions; Financing; Obligations; Capital Accounts

3.1 **Contributions and Financing.**

3.1.1 Each of the Members has contributed property or services to the Company in proportion to their respective Membership Interests as set forth in Section 2.6 hereof as the same may be amended from time to time.

3.1.2 The Members may, from time to time, seek financing at prevailing interest rates and otherwise upon terms and conditions satisfactory to the Members to assist in funding the operations of the Company.

3.1.3 To the extent required by any bank, financial institution or any other lender ("Lender") as a condition to making loans hereunder, each of the Members shall execute and deliver or cause to be executed and delivered, any personal guarantees and related documents required by the Lender. The Members, to the extent permitted by Lender, shall be liable with respect to any such personal guarantees only to the extent of their proportionate Membership Interests and if not so permitted by Lender shall as amongst themselves only be liable with respect to their proportionate Membership Interest.

3.2 **Obligations.** Each of the Members will cooperate in all aspects to procure financing, refinancing, licenses and insurance (including, without limitation, self-insurance) on behalf of the Company and in all other matters with respect to the proper and efficient operation of the Company.

3.3 **Capital Accounts.** An individual capital account (a "Capital Account") shall be established and maintained for each Member in compliance with Regulation §1.704-1(b).

ARTICLE FOUR

Members Not Liable for Company Losses

4.1 **No Liability.** The Members shall have no personal liability for the losses, debts, claims or expenses of, or encumbrances against, the Company or its property.

ARTICLE FIVE

Distributions

5.1 **Distributions Generally.**

5.1.1 Except as otherwise provided in this Section 5.1, the timing and amount of any distribution of funds of the Company shall be determined by the Members.

5.1.2 The Company shall retain funds necessary to cover its reasonable business needs, which shall include reserves against possible losses and the payment and making provision for the payment, when due, of obligations of the Company, including obligations owed to Members, and may retain funds for any other Company purposes. The amounts of such reserves and the purposes for which such reserves are made shall be determined by the Members.

5.2 **Apportionment of Distributions**. Except as provided in Sections 5.1 and 8.2 hereof, distributions shall be made to the Members in proportion to their respective Membership Interests.

ARTICLE SIX

Allocations

6.1 **Allocations of Net Income and Net Loss**. After making the allocations (if any) required by Section 6.2 hereof, all Net Income and Net Loss for each fiscal year (or portion thereof) of the Company shall be allocated among the Members in accordance with their respective Membership Interests.

6.2 **Regulatory Allocations**.

6.2.1 Notwithstanding any other provision of this Agreement, Net Loss (or items of deduction as computed for book purposes) shall not be allocated to a Member to the extent that the Member has or would have, as a result of such allocation, an Adjusted Capital Account Deficit. An "Adjusted Capital Account Deficit" shall mean and refer to a Member's Capital Account, increased by any amounts which such Member is obligated to restore pursuant to the terms of this Agreement or is deemed to be obligated to restore pursuant to the penultimate sentences of Regulation §1.704-2(g)(1) and §1.704-2(i)(5), and reduced by any adjustments, allocations or distributions described in Regulation §1.704-1 (b)(2)(ii)(d)(4), (5) or (6). Any Net Loss (or items of deduction as computed for book purposes) which otherwise would be allocated to a Member, but which cannot be allocated to such Member because of the application of the immediately preceding sentence, shall instead be allocated to the other Members, in accordance with their respective Percentage Interests, subject to the limitation imposed by the immediately preceding sentence.

6.2.2 In order to comply with the "qualified income offset" requirement of the Regulations under Code § 704(b), and notwithstanding any other provision of this Agreement to the contrary, except Section 6.2.3, in the event a Member for any reason (whether or not expected) has an Adjusted Capital Account Deficit, items of Net Income (consisting of a pro rata portion of the items thereof) shall be allocated to such Member in an amount and manner sufficient to eliminate as quickly as possible the Adjusted Capital Account Deficit.

6.2.3 In order to comply with the "minimum gain charge back" requirements of Regulation § 1.704-2(f)(1) and § 1.704-2(i)(4), and notwithstanding any other provision of this Agreement to the contrary, in the event there is a net decrease in a Member's share of Company minimum gain (as defined in Regulation § 1.704-2(d)(1)) and/or Member non-recourse debt minimum gain (as defined in Regulation § 1.704-2(i)(2)) during a Company taxable year, such Member shall be allocated items of income and gain for that year (and if necessary, for other years) as required by and in accordance with Regulation § 1.704-2(f)(1) and § 1.704-2(i)(4) before any other allocation is made.

6.2.4 Notwithstanding any other provision of this Agreement, all items of deduction and loss that, pursuant to Regulation §1.704-2(i), are attributable to a non-recourse debt for which a Member (or a Person related to such Member under Regulation §1.752-4(b)) bears the economic risk of loss (within the meaning of Regulation §1.752-2), shall be allocated to such Member as required by Regulation §1.704-2(c).

6.3 **Other Allocation Rules**.

6.3.1 Each separate item of income, deduction, gain and loss of the Company shall be allocated among the Members in the same proportion as the portion of the total Net Income or Net Loss for the period which is credited or charged to the Capital Account of each Member bears to the total Net Income or Net Loss for such period.

6.3.2 Income, gain, loss and deductions of the Company shall, solely for income tax purposes, be allocated among the Members in accordance with Code § 704(c), so as to take account of any difference between the adjusted basis of the assets of the Company for Federal income tax purposes and their respective Gross Asset Values, and otherwise shall be allocated in the same manner as the related book items were allocated under Sections 6.1 and 6.2 hereof. Except as otherwise determined by the Managers, any allocations required by Code § 704(c) shall be effectuated using the traditional method described in Regulation §1.704-3(b)(1).

ARTICLE SEVEN

Dispositions of Membership Interests

7.1 **Transfers of Membership Interests**. Except for a Transfer pursuant to Section 7.2 or 7.4 of this Agreement, no Member shall have the right to Transfer or otherwise dispose of all or any portion of his Membership Interest in the Company, except with the unanimous consent of the non-transferring Members (which consent may be granted or withheld in their sole and absolute discretion); provided, however, that the Members are under no restrictions as to the transfer by them of their Membership Interest among themselves or to their Affiliates and that upon the death of a Member, such Member's right to receive distributions under this Agreement may be transferred to his estate or beneficiaries, but such Affiliate(s) and/or transferee(s) shall acquire no other rights hereunder unless admitted as Members in accordance with the provisions of Section 7.3 hereof.

7.2 Sales to Third Parties. Except as set forth in Section 7.4 hereof, if a Member (the "Offeror") shall at any time desire to sell all, but not less than all, of his Membership Interest (the "Offered Membership Interest") to a third party and the Proposed Purchaser shall have made a firm commitment to purchase all of such Offered Membership Interest (the "Third Party Offer"), then:

(a) The Offeror shall give written notice (the "Offer Notice") to the Company and to each of the other Members (the "Offerees") of his desire to sell all of his Offered Membership Interest, which notice shall (i) state the name and address of the Proposed Purchaser and (ii) the purchase price and the other terms and conditions on which the Offeror proposes to sell the Offered Membership Interest to the Proposed Purchaser (the "Third Party Terms"). The Offer Notice shall constitute an offer to sell first to the Company and then to the other Offerees all of the Offered Membership Interest upon the Third Party Terms.

(b) The Company shall have a period of 30 days after its receipt of the Offer Notice within which to accept, in whole or in part, the offer made by the Offer Notice by giving concurrent notice to such effect to the Offeror and to each of the other Offerees within such period. If the Company does not accept the offer made by the Offer Notice in whole, each Offeree, other than the Company, shall have the right, for a period of fifteen days after the expiration of the Company's 30-day option period, to accept the offer made by the Offer Notice to the extent not accepted by the Company, by giving concurrent notice to such effect to the Offeror and to each of the other Offerees (including the Company) within such fifteen day period. Each such notice of acceptance shall specify the amount of the Offered Membership Interest which the Offeree giving such notice is willing to purchase provided the remaining Offered Membership Interest is purchased by the other Offerees.

(c) If any or all of the Offerees shall accept the offer made by the Offer Notice and if they shall collectively specify in their notices of acceptance their willingness to purchase all of the Offered Membership Interest, then:

(i) If the Company shall so accept such offer (whether it shall have so specified it is willing to purchase all or less than all of the Offered Membership Interest), the Offeror shall sell to the Company, and the Company shall purchase from the Offeror, on the Third Party Terms, the Membership Interest which the Company shall have so specified that it is willing to purchase.

(ii) If either the Company shall not so accept such offer to any extent or shall have so accepted such offer as to less than all of the Offered Membership Interest, then the Offeror shall sell to each of the Offerees, other than the Company, who shall have so accepted such offer, and each such other Offeree shall purchase from the Offeror, on the Third Party Terms, the Offered Membership Interest equal to the product of (a) the balance of the Offered Membership Interest which is not required to be sold to the Company by such Offeror pursuant to clause (i) above and (b) a fraction, the numerator of which shall be the Membership Interest which such Offeree shall own and the denominator of which shall be the Membership Interests which all of the Offerees who shall have accepted such offer shall own; provided, however, that no Offeree shall be required to purchase more Offered Membership Interest than such Offeree shall have so specified that such Offeree is willing to purchase in its notice of acceptance, and any Offered Membership

Interest not so required to be purchased by such Offeree shall be allocated among the other Offerees, to the extent that they are willing to purchase the same, in accordance with the foregoing provisions of this clause (ii); and provided, further, that the Offerees may agree among themselves to allocate the Offered Membership Interest to be purchased by each Offeree other than in their respective proportionate amounts, in which event, the Offerees shall give written notice of such allocation to the Company and the Offeror.

(d) Each Offeree, other than the Company, that has not accepted the offer made by the Offer Notice, shall have the right within 15 days of its receipt of the Offer Notice to elect, by written notice to the Offeror (the "Tag-Along Notice"), to require the Proposed Purchaser to purchase from such Offeree, on the Third Party Terms, up to the same proportion of the aggregate Membership Interests of the Company held by such Person as the proportion of aggregate Membership Interests of the Company owned by the Offeror that is sold to such Proposed Purchaser; provided, however, that if any other Offeree elects to accept the offer made by the Offer Notice, then the Offeree not a party to such election shall not have the right to require either the other Offerees or the Proposed Purchaser to purchase such Person's Membership Interests. Each Offeree who fails to deliver a Tag-Along Notice to the Offeror prior to the expiration of the 15-day period referred to in the preceding sentence shall forfeit all of such Offeree's rights pursuant to this paragraph (d).

(e) If none of the Offerees shall accept the offer made by the Offer Notice or if any or all of the Offerees shall so accept such offer but they shall not collectively accept and thereafter purchase all of the Offered Membership Interest within the time frames set forth in Section 7.2(b), then: (i) the Offeror shall not be obligated to sell any of the Offered Membership Interest to any Offeree; provided, however, that if the Offeror elects to sell any of the Offered Membership Interest to any Offeree, he must sell all of the Offered Membership Interest with respect to which Offerees have exercised their options pursuant to this Section 7.2 and (ii) within 90 days after the giving of the Offer Notice, the Offeror shall have the right to sell all, but not less than all, of the Offered Membership Interest to the Proposed Purchaser; provided, however, that any such sale shall be subject to all of the following conditions:

(i) The sale to the Proposed Purchaser shall be at the price, upon the terms and in the manner set forth in the Offer Notice.

(ii) The Proposed Purchaser shall not become a "Member" unless all of the non-transferring Members consent, which consent shall not unreasonably be withheld; provided, however, that such Proposed Purchaser shall obtain the Transferor's right to receive distributions under this Agreement from and after the date of such sale.

(iii) At the time of any sale and purchase of Offered Membership Interest, the Proposed Purchaser shall deduct from the purchase price and shall pay to the Company any amount owed by the Offeror to the Company.

(f) In the event that the Offeror, or more than one Offeror, has complied with the procedures set forth in this Section 7.2 after receiving a Third Party Offer, and the Offered Membership Interest constitutes more than 85% of the aggregate Membership Interests of the

Company, each Offeree that has not elected to purchase the Offered Membership Interest shall, upon the written request of the Proposed Purchaser, be required to sell to such Proposed Purchaser, on the Third Party terms, the same proportion of the aggregate Membership Interests of the Company held by such Person as the proportion of aggregate Membership Interests of the Company owned by the Offeror(s) that is sold to such Proposed Purchaser.

(g) If the Offeror shall not so sell the Offered Membership Interest to the Proposed Purchaser within the 90-day period specified in Section 7.2(e), the Offeror shall continue to hold the Offered Membership Interest subject to all of the terms and conditions of this Agreement.

(h) If the Company or some or all of the Offerees elect to exercise the right and option to purchase set forth in this Section 7.2, settlement of the purchase shall take place on the sixtieth day from the date of the Offer Notice at the office of the Company, at which time and place the Offeror shall tender an appropriate instrument of assignment evidencing the transfer of the Offered Membership Interest being sold, and the purchasers shall tender the purchase price in the form and manner prescribed in the Third Party Offer.

7.3 **Substitute Members**. Notwithstanding anything to the contrary contained in this Agreement, the assignee of a Membership Interest shall have the right to become a substituted Member in the Company only if (1) the consent referred to in Section 7.1 or Section 7.2(e)(ii) has been obtained, (2) the assignor so provides in an instrument of assignment, (3) the assignee agrees in writing to be bound by the terms of this Agreement and the Articles of Organization in the form attached hereto as Exhibit A, and (4) the assignee pays the reasonable costs incurred by the Company in preparing and recording any necessary amendments to this Agreement and the Articles of Organization, unless waived by Consent of the Manager.

7.4 **Qualified Transferee.** Each Member shall be free to give, sell, assign, transfer or bequeath all or any part of their Membership Interest to any spouse, children or issue of such Member ("Qualified Transferee"), provided that such Qualified Transferee shall execute a counterpart of this Agreement and agree to be bound by all of the terms hereof, and such Member (if then living and competent) shall agree to guaranty any and all then outstanding obligations of such transferee to the Company or to any other Members incurred pursuant to this Agreement. Furthermore, any Member may transfer, assign, convey or bequeath any or all of their Membership Interest to any trust of which such Member, any other Member or any Qualified Transferee is the trustee, provided that (i) such Member shall give the Company thirty (30) days' prior written notice of the proposed transfer, accompanied by a copy of the trust agreement or other instrument creating such trust and (ii) the trustees of such trust shall execute a counterpart of this Agreement and agree to be bound by all of the terms hereof.

7.5 Notwithstanding anything to the contrary herein or in the Articles of Organization, transfers, assignments or other dispositions or membership interests or voting rights must be effectuated in accordance with section 2801-a(4)(b) of the New York State Public Health Law and implementing regulations.

ARTICLE EIGHT

Dissolution, Liquidation and Termination

8.1 Dissolution.

8.1.1 The Company shall dissolve upon, but not before, the first to occur of the following:

(a) By the affirmative vote of the Members holding not less than 85% of the Membership Interests;

(b) The disposition of all or substantially all of the assets of the Company;

(c) The Bankruptcy, death, disability, expulsion or voluntary withdrawal of any Member, unless the holders of at least 85% of the remaining Membership Interests agree to continue the business of the Company within 90 days after such event; or

(d) Any other event that would cause the dissolution of a limited liability company under the Act, unless the remaining Members agree to continue the business of the Company within 90 days after such event.

8.1.2 Upon the dissolution of the Company, the Company shall immediately commence to wind up its affairs, and the Manager shall proceed with reasonable promptness to liquidate the business of the Company.

8.1.3 During the period of the winding up of the affairs of the Company, the rights and obligations of the Members shall continue as provided herein.

8.2 Liquidation. The Company shall terminate after its affairs have been wound up and its assets fully distributed in liquidation as follows:

(a) first, to the payment of the debts and liabilities of the Company and the Company's expenses of liquidating;

(b) next, to the setting up of any reserves which the Members may deem reasonably necessary for any contingent or unforeseen liabilities or obligations of the Company, provided that any reserves not necessary to satisfy such liabilities or obligations are distributed as soon as practicable; and

(c) thereafter, to the Members, in proportion to their respective positive Capital Accounts.

8.3 Cancellation of Articles of Organization of the Company. Upon the completion of the liquidation of the Company's property, the Members shall cause the cancellation of the Articles of Organization.

ARTICLE NINE

Company Property

9.1 **Company Property**. The Company's property shall consist of all Company assets and all Company funds. Title to the property and assets of the Company may be taken and held only in the name of the Company or in such other name or names as shall be determined by the Members. All property now or hereafter owned by the Company shall be deemed owned by the Company as an entity and no Member, individually, shall have any ownership of such property. Title to the assets and properties, real and personal, now or hereafter owned by or leased to the Company, shall be held in the name of the Company or in such other name or names as the Managers shall determine; provided, however, that if title is held other than in the name of the Company, the Person or Persons who hold title shall certify by instrument duly executed and acknowledged, in form for recording or filing, that title is held as nominee and/or trustee for the benefit of the Company pursuant to the terms of this Agreement and an executed copy of such instrument shall be delivered to each Member.

9.2 **Prohibition Against Partition**. Each Member hereby permanently waives and relinquishes any and all rights he or she may have to cause all or any part of the property of the Company to be partitioned, it being the intention of the Members to prohibit any Member from bringing a suit for partition against the other Members, or any one of them.

ARTICLE TEN

Records and Accounting; Fiscal Affairs

10.1 **Fiscal Year**. The fiscal year of the Company shall be the calendar year.

10.2 **Bank Accounts**. All funds of the Company shall be deposited in such bank or savings and loan account or accounts as shall be designated by the Members. Withdrawals from any such bank account shall be made upon such signature or signatures as the Members may designate, and shall be made only for the purposes of the Company.

10.3 **Books and Records**. The Members shall, at the Company's cost and expense, maintain full and accurate books of the Company, in accordance with the Company's accounting policies consistently applied, at the principal place of business of the Company, showing all receipts and expenditures, assets and liabilities, Net Income or Net Loss, and all other records necessary for recording the Company's business and affairs, including those sufficient to record the allocations and distributions provided for in this Agreement. The books and records shall, upon reasonable prior notice to the Company, be open for inspection and copying by any Member or his or her duly authorized representatives during regular business hours at such principal place of business. Any expense for any inspection or examination shall be borne by the Member causing such inspection or review to be conducted. Any information obtained by a Member with respect to the affairs of the Company shall, except as may be required by law, be kept strictly confidential.

10.4 Tax Status. Each of the Members hereby recognizes that the Company will be treated as a partnership for Federal, state and local income tax purposes and will be subject to all provisions of Subchapter K of Chapter I of Subtitle A of the Code.

10.5 Tax Returns; Elections.

10.5.1 The Members shall cause all income tax and information returns for the Company to be prepared by the Company's accountant and shall cause such tax returns to be timely filed with the appropriate authorities. All decisions regarding tax elections shall be made by the Members. Copies of such tax and information returns shall be kept at the principal office of the Company or at such other place as the Members shall determine and shall be available for inspection by the Members or their representatives during normal business hours. Each Member shall be furnished within 90 days after the end of each fiscal year with such information as may be necessary to enable each Member to file his Federal income tax return and any required state income tax return. The Members shall cause the Company to pay, out of available cash flow and other assets of the Company, any taxes payable by the Company.

10.5.2 The Company may, but is not required to, make elections for income tax purposes to the extent permitted by applicable law and regulations, as follows:

(1) in case of a transfer of all or part of any Member's Membership Interest, the Company may elect in a timely manner pursuant to § 754 of the Code and pursuant to corresponding provisions of applicable state and local tax laws to adjust the bases of the assets of the Company pursuant to §§ 734 and 743 of the Code; and

(2) all other elections required or permitted to be made by the Company shall be made in such a manner as the Member, in consultation with the Company's attorneys or the Company's accountant, determine to be most favorable to the Members.

10.5.3 Each Member agrees to report, on his own income tax returns each year, each item of income, gain, loss, deduction and credit as reported by the Company to such Member on the Schedule K-1 (or other similar tax report) issued by the Company to such Member for such year. Except as otherwise required by law, no Member shall take any tax reporting position that is inconsistent in any respect with any tax reporting positions taken by the Company or any entity in which the Company owns any equity interest, and, in the event of a breach by such Member of the provisions of this Section 10.5.3, shall be liable to the Company and the Members for any costs, liabilities and damages (including, without limitation, consequential damages) incurred by any of them on account of such breach.

10.6 Tax Matters Member. Pursuant to Code § 6231(a)(7)(A), Fuchs is hereby designated as the "Tax Matters Member" of the Company for all purposes of the Code and for the corresponding provision of any U.S. state or local statute. All of the Members hereby consent to such designation and agree to take any such further action as may be required by applicable tax law to effectuate and maintain such designation. The Members may from time to time designate another Member as the Tax Matters Member.

ARTICLE ELEVEN

Confidentiality

11.1 **Confidentiality**. The Members agree that each of them will treat in confidence this Agreement and all documents, materials and other information concerning this Agreement or the Company.

ARTICLE TWELVE

Miscellaneous

12.1 **Independent Activities**. Each Member may engage in any investment or business activities of his choice, including, without limitation, the ownership and operation of nursing home facilities, independent of the Company without having or incurring any obligation to offer any interest in such activities to the Company or any other Member, provided that such activities do not directly compete with the business of the Company.

12.2 **Notice**. Notice to any Member shall be sent to such Member at his address, as hereinabove set forth or to such other address as such Member shall designate in writing to the other Members. Any notice to the Company shall be sent to the attention of the other Members at the address herein above set forth or to such other address as the Members shall designate in writing to the other Members. All communications required or permitted to be given hereunder shall be in writing and shall be deemed to have been duly given if (i) delivered personally with receipt acknowledged, (ii) sent by registered or certified mail, return receipt requested, (iii) transmitted by facsimile (which shall be confirmed by a writing sent by registered of certified mail on the same day that such facsimile is sent) or (iv) sent by recognized overnight courier for next business day delivery signature required. Notice of change of address shall be deemed given when actually received or upon refusal to accept delivery thereof; all other communications shall be deemed to have been given, received and dated on the earlier of: (i) when actually received or upon refusal to accept delivery thereof, (ii) on the date when delivered personally, (iii) one day after being sent by overnight courier or (iv) two business days after facsimile and mailing, as aforesaid.

12.3 **Separability**. In case any one or more of the provisions contained in this Agreement shall be invalid or unenforceable in any respect, the validity and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby and the parties will attempt to agree upon a valid and enforceable provision which shall be a reasonable substitute for such invalid and unenforceable provision in light of the tenor of this Agreement and, upon so agreeing, shall incorporate such substitute provision in this Agreement.

12.4 **Interpretation**. This Agreement shall be interpreted and construed in accordance with the laws of the State of New York. The parties hereby consent to personal jurisdiction and venue in the State of New York, County of New York, with respect to any action or proceeding brought in connection with this Agreement. All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular, or plural as the identity of the Person or Persons referred to may require. The captions of sections of this Agreement have been inserted as a matter of convenience only and shall not control or affect the meaning or construction of any of the terms or provisions hereof.

12.5 **Entire Agreement**. This Agreement sets forth the entire understanding and agreement of the parties hereto with respect to subject matter hereof and all prior agreements arrangements and understandings among the parties with respect to the subject matter hereof are superseded by this Agreement, which integrates all promises, agreements, conditions and understandings among the parties with respect to the Company and its property.

12.6 **Termination, Revocation, Waiver, Modification or Amendment**. No termination, revocation, waiver, modification or amendment of this Agreement shall be binding unless agreed to in writing by all of the parties hereto.

12.7 **Binding Effect**. This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and, subject to the restrictions on Transfer set forth in Article Seven, their respective successors, permitted assigns, heirs, executors, administrators and legal representatives.

12.8 **Further Assurances**. Each of the parties hereto agrees to execute, acknowledge, deliver, file, record and publish such further certificates, instruments, agreements and other documents, and to take all such further actions as may be required by law or deemed by the Members to be necessary or useful in furtherance of the Company's purposes and the objectives and intentions underlying this Agreement and not inconsistent with the terms hereof.

12.9 **Waiver**. No consent or waiver, express or implied, by any Member to or of any breach or default by any other Member in the performance by any other Member of his obligations hereunder shall be deemed or construed to be a consent to or waiver of any other breach or default in the performance by such other Member of the same or any other obligation of such Member hereunder. Failure on the part of a Member to complain of any act or failure to act of any other Member or to declare such other Member in default, irrespective of how long such failure continues, shall not constitute a waiver by such Member of his rights hereunder.

12.10 **Additional Remedies**. The rights and remedies of any Member hereunder shall not be mutually exclusive. The respective rights and obligations hereunder shall be enforceable by specific performance, injunction or other equitable remedy, but nothing herein contained is intended to limit or affect, nor shall it limit or affect, any other rights in equity or any rights at law or by statute or otherwise of any party aggrieved as against the other for breach or threatened breach of any provision hereof, it being the intention of this paragraph to make clear the agreement of the parties hereto that their respective rights and obligations hereunder shall be enforceable in equity as well as at law or otherwise. The parties hereto recognize that any breach of the terms of this Agreement may give rise to irreparable harm for which money damages would not be an

adequate remedy, and accordingly agree that, in addition to any other remedies a party may have available at law or in equity, any non-breaching party shall be entitled to enforce the terms of this Agreement by decree of specific performance without the necessity of proving the inadequacy as a remedy of money damages.

12.11 **No Reliance by Third Parties**. The provisions of this Agreement are not for the benefit of any creditor or other Person other than a Member and no creditor or Person shall obtain any rights under this Agreement or by reason of this Agreement.

12.12 **Arbitration**. Any controversy arising out of or relating to this Agreement or any modification or extension thereof, shall be settled by arbitration before a panel of three arbitrators in New York City in accordance with the rules then pertaining to the American Arbitration Association. Such decision shall be final and binding upon the parties hereto. The parties consent to the jurisdiction of the Supreme Court of the State of New York, and of the United States District Court for the Southern District of New York, for all purposes in connection with arbitration, including the entry of judgment on any award. The parties consent that any process, notice of motion or other application to either of said courts, and any papers in connection with arbitration, may be served by registered or certified mail, return receipt requested, by personal service, or in such other manner as may be permissible under the rules of the applicable court or arbitration tribunal, provided a reasonable time for appearance is allowed. The arbitrators shall have no power to alter or modify any express provision of this Agreement or to render an award which has the effect of altering or modifying any express provision hereof.

12.13 **Counterparts**. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which shall constitute one agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written.

Bernard Fuchs

EXHIBIT 16

Exhibit 13 - Guarantor Analysis

Ownership for the PropCo and Opco is as follows:

- Ephram Lahasky, Sam Halper, Rafi Lichtschein, David Gast, and Bernard Fuchs - 16.6%
- Josh Farkowits - 8.4%
- Benjamin Landa - 8.4%

Mordy Lahasky

Ephram "Mordy" Lahasky graduated Magna Cum Laude from Touro College in 1987 with dual majors in Computer Science and Mathematics. After working in the finance department at Paine Webber, Mr. Lahasky was hired as a computer programmer for The Long Island Rail Road. Mr. Lahasky was a key member of the team which developed and maintained all of the computer programs used to track payroll, time and attendance and pension systems. After ten years as a union employee of the LIRR, Mr. Lahasky was promoted to Manager of the Information Technology department. As Manager of the Information Technology department, Mr. Lahasky was involved in implementing some of the most cumbersome collective bargaining agreements of any union workforce in New York State. Mr. Lahasky, having been a union employee and then having the opportunity to manage union employees, has a unique perspective and understanding of how to mesh both management and labor- force needs.

Since retiring from The LIRR in 2007, Mr. Lahasky went on to turn around distressed medical transportation companies in the tri-state area and develop them into class leading companies. In 2011, Mr. Lahasky ventured into acquiring distressed Senior Care facilities in the New York and New Jersey area with three homes. In 2014, he was a partner in the group that acquired Friendship Ridge, a 589-bed home financed by the Bank. He has subsequently closed on additional skilled nursing opportunities with CIBC. Having 20 years of union labor experience with the Metropolitan Transportation Authority, combined with his track record of reviving distressed medical transportation companies and health care facilities, gives Mr. Lahasky a unique understanding of the way state-run and non-profit organizations are operated. Mr. Lahasky is actively pursuing acquisitions of county and non-profit owned nursing facilities because his experience uniquely enables him to successfully transition these facilities into the private sector.

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Ephraim (Mordy) Lahasky	09/2020	2018	$73,973,106	$1,235,501	$72,737,605	$72,737,605	$1,045,000	$12,909,875	$86,508,638

9/19/2020

ASSETS		LIABILITIES	
Cash	1,045,000	Home Mortgages	835,501
Partnerships	69,744,211	Real Estate	400,000
Accounts & Notes Receivable	82,444	**TOTAL LIABILITIES**	**1,235,501**
Residential Real Estate	1,478,910		
Retirement Accounts	1,622,541	**EQUITY**	
		TOTAL EQUITY	**72,737,605**
TOTAL ASSETS	**73,973,106**	**TOTAL LIABILITIES & EQUITY**	**73,973,106**

Sam Halper

Sam Halper has been in Administrator/Assistant Administrator roles since May 2007. He was recruited by the other principals for the Friendship opportunity and was relocated from New York to Pittsburgh to run the facility. From April 2012 to November 2013, Halper was the Administrator of River Manor Care Center, a 380-bed SNF in Brooklyn, NY. During his 1.5-year tenure there, he increased average daily census from 93% to 97%, Medicare mix from 7% to 12% (equating with 19 additional patients per day), and increased the average Medicaid rate by $29.31/day (13%). Halper also reduced overall payroll by $1mln (10%) and overall expenses by $2mln (5%).

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Sam Halper	08/2020	2018	$51,221,153	$28,329,079	$22,892,074	$22,892,074	$4,000,000	$4,658,624	$87,725,000

8/1/2020

ASSETS		LIABILITIES	
Cash	4,000,000	Health Care Facilities	28,329,079
Health Facility Realty Interests	47,221,153		
Other Investments	350,000	**TOTAL LIABILITIES**	**28,329,079**
		EQUITY	
		TOTAL EQUITY	**22,892,074**
TOTAL ASSETS	**51,221,153**	**TOTAL LIABILITIES & EQUITY**	**51,221,153**

David Gast

David Gast has been the Director of Operations of New Real Estate Capital in Bucharest, Romania since 2007. He is also the owner of two apartment buildings: a 500-unit building in Bronx, NY and a 54-unit building in Zurich, Switzerland.

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
David Gast	11/2020	2019	$52,448,200	$30,257,153	$22,191,047	$22,191,047	$350,000	$4,973,021	$31,104,504

11/17/2020

ASSETS		LIABILITIES	
Cash	350,000	**TOTAL LIABILITIES**	**30,257,153**
Real Estate Investments	52,098,200	**EQUITY**	
		TOTAL EQUITY	**22,191,047**
TOTAL ASSETS	**52,448,200**	**TOTAL LIABILITIES & EQUITY**	**52,448,200**

Bernard Fuchs

Bernard Fuchs founded Lenoxx Electronics Corp. in 1975 and served as its Chief Executive Officer from 1975 until 2007. Lenoxx was a contract manufacturer of electronics that at its peak generated over $500mln a year in revenues and serviced major retail outlets throughout the world, including Walmart USA and its worldwide subsidiaries. Under Mr. Fuchs' leadership, Lenoxx received the Vendor of the Year award from Walmart for eight years in a row, which recognizes vendors that supply quality merchandise and excellent service. Mr. Fuchs managed relationships with 25 factories in four countries (Japan, Korea, Taiwan and China) and administered over 60thd employees.

Since retiring from Lenoxx, Mr. Fuchs has diversified his personal portfolio by investing in numerous alternative asset funds and many projects, including real estate and several health care facilities. Mr. Fuchs' SNF acquisitions include Hopkins Center for Rehabilitation and Healthcare and Bensonhurst Center for Rehabilitation and Healthcare. Hopkins Center, formerly Bishop Mugavero Center for Geriatric Care is a 288 bed Skilled Nursing Facility located in Brooklyn, N.Y. and Bensonhurst Center, formerly Holy Family Home, is a 200 bed Skilled Nursing Facility located in Brooklyn, N.Y. He successfully streamlined operations to realize efficiencies and increase profitability at these homes.

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Bernard Fuchs	10/2020	2019	$43,889,025	$0	$43,889,025	$43,889,025	$10,841,612	$3,686,024	$24,047,413

10/31/2020

ASSETS		LIABILITIES	
Cash	10,841,612	**TOTAL LIABILITIES**	-
Residential Real Estate	8,500,000		
Health Facilities Interests	24,047,413	**EQUITY**	
Personal Property	500,000	**TOTAL EQUITY**	**43,889,025**
TOTAL ASSETS	**43,889,025**	**TOTAL LIABILITIES & EQUITY**	**43,889,025**

EXHIBIT 17

Collateral Details

Real Estate Collateral – Term Loan

REAL ESTATE COLLATERAL									
Item / Address/ Parcel ID No. (PIN)	**Appraisal Date/ Value Date**	**Appraiser**	**Approach to Value**	**Value**	**% Occupied**	**# of Units**	**% RE Mix***	**Advance Rate Per Policy**	**Loanable Value**
14012 Route 31 West Albion, NY 14411	*11/17/2016*	HealthTrust	*As-Is*	$14,400,000	96%	120 Beds	N/A	80%	**$11,520,000**
Cash Account								100%	**$3,700,000**
PROPERTY TYPE**:	*SNF*	FUNDS LIMITED TO:	*80.0% LTV*	OWNER OCCUPIED REAL ESTATE:	*Yes*	IF OWNER OCCUPIED, PRIMARY RESIDENCE:	*No*	IS IT HELD IN A LAND TRUST?	*No*
								Less Loan Amount	**($15,000,000)**
								Excess (Deficit) Collateral	**$220,000**

Collateral Description

- Based on the "As-Is" value of $14.4mln per the 11/17/16 appraisal, the LTV is 78.5% (net of cash collateral).
- The subject facility is a 120-bed skilled nursing facility in Albion, NY.
- The one-story building is 77thd SF and the site size is 9.3 acres. The facility was built in 1960 with major renovations in 1995 & 2007. There are three nurses stations, 186 parking spaces, and three dining rooms. Building construction is concrete slab, steel frame with brick veneer.
- The home is not in a flood zone.
- Account balances as of 12/5/2017:
  - Collateral Account: $3,703,748
  - CapEx Account: $711,232
  - Principal Sinking Fund: $245,041. Please see below for the projected account balance over the next six months.

Telegraph Realty LLC	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Actual Balance	$ 128,522	$ 151,822	$ 175,126	$ 198,430	$ 221,735	$ 245,041
	Jan-18	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**
Projected Balance	$ 268,300	$ 291,600	$ 314,900	$ 338,200	$ 361,500	$ 384,800

SLTV Chart

Loan To Value Control; Internal & Supervisory Limits	
Credit Name:	Telegraph Realty LLC
Location of property:	14012 Route 31 West, Albion, NY
Category of property:	Improved
Appraisal Date:	11/17/2016
Appraiser:	HealthTrust
Appraised as:	As Is
Appraised Value:	14,400,000
Acquisition Cost if Purpose of this LP:	N/A
Correct Valuation Basis:	N/A
Approved & Applied Advance Rate:	78%
Loanable Value per Appraisal	11,300,000
Loanable Value per Acq. Cost	N/A
Internal Advance Rate Exception:	**No**
Supervisory LTV Exception:	**No**

Going Concern Real Estate - Lendable Value Analysis

Date: 12/2/2016

Borrower Per LP: Telegraph Realty, LLC — Property Type: SNF
Commitment: 11,300,000 *(net of any cash collateral)* — Cash Collateral: 3,700,000
Outstanding: 11,300,000 *(net of any cash collateral)*

Appraiser & Appraisal Date: HealthTrust 11/17/2016 *(If multiple dates, enter Various)*
No. of Properties in Appraised Value:
Tot. Appraised Value - As Complete: ..... Effective Adv. Rate: 0%
Tot. Appraised Value - As Stabilized/As is Marke: 14,400,000 ..... Effective Adv. Rate: 78%
or As is Fee Simple

Applied Advance Rates

		Internal Exception	SLTV Exception
Land:	50%	NO	NO
Improvements:	80%	NO	NO
FF&E:	80%	NO	
Business Value:	80%	NO	

Standard Advance Rates for Healthcare Lendable Value

	Internal	SLTV
Land:	50%	65%
Improvements:	80%	85%
FF&E:	80%	
Business Value:	80%	

Aggregate Value Components of Appraisal:

Land:	590,000	4%
Real Property/Improvements	10,910,000	76%
Personal Prop./FF&E:	600,000	4%
Business Value:	2,300,000	16%

Lendable Value Coverage:

Lendable Value:	11,343,000
Excess or (Shortfall):	43,000

Property Level Detail of Value Components:

Property Name	Total Stabilized Appraised Value	Land	Real Property or Improvement	Personal Prop. or FFE	Business Value	Lendable Value	Eff. Adv. Rate
Telegraph Realty, LLC	14,400,000	590,000	10,910,000	600,000	2,300,000	11,343,000	79%

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Mordy Lahasky

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PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Ephraim (Mordy) Lahasky	05/2017	2016	$105,856,370	$650,000	$105,206,370	$105,206,370	$4,302,005	$7,023,756	$92,295,000

5/17/2017

ASSETS		LIABILITIES	
Cash	1,702,000	Home Mortgages	650,000
Non-Marketable Securities	2,600,005	Unsecured Loans	66,300,447
Accounts & Notes Receivable	638,611	Secured Loans	500,000
Residential Real Estate	1,300,000	**TOTAL LIABILITIES**	**650,000**
Partnerships	99,615,754	**EQUITY**	
		TOTAL EQUITY	**105,206,370**
TOTAL ASSETS	**105,856,370**	**TOTAL LIABILITIES & EQUITY**	**105,856,370**

Global Cash Flow: Lahasky has GCF of $7mln consisting of $1mln from ambulance and consulting ventures and $6mln from skilled nursing facility investments.

Sam Halper

Sam Halper has been in Administrator/Assistant Administrator roles since May 2007. He was recruited by the other principals for the Friendship opportunity and was relocated from New York to Pittsburgh to run the facility. From April 2012 to November 2013, Halper was the Administrator of River Manor Care Center, a 380-bed SNF in Brooklyn, NY. During his 1.5-year tenure there, he increased average daily census from 93% to 97%, Medicare mix from 7% to 12% (equating with 19 additional patients per day), and increased the average Medicaid rate by $29.31/day (13%). Halper also reduced overall payroll by $1mln (10%) and overall expenses by $2mln (5%).

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Sam Halper	05/2017	2016	$8,095,000	$0	$8,095,000	$8,095,000	$560,000	$4,658,624	$87,725,000

5/16/2017

ASSETS		LIABILITIES	
Cash	560,000	**TOTAL LIABILITIES**	-
Privately Owned Business (net)	7,535,000	**EQUITY**	
		TOTAL EQUITY	**8,095,000**
TOTAL ASSETS	**8,095,000**	**TOTAL LIABILITIES & EQUITY**	**8,095,000**

Raphael "Rafi" Lichtschein

Rafi Lichtschein is the operations manager at King David Manor which is located in Brooklyn, NY. King David Manor is a real estate company with an annual budget of over 5 million dollars. Additionally he is a consultant and advisor for Surf Manor Home for Adults also located in Brooklyn, NY. Surf Manor is a health care facility with an annual operating budget over 3 million dollars. At Surf Manor he is involved with the residents and daily operations. He oversees all special projects and functions.

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Raphael Lichtschein	03/2017	2015	$5,950,000	$0	$5,950,000	$5,950,000	$500,000	$345,000	$4,470,000

3/6/2017

ASSETS		LIABILITIES	
Cash	250,000	None	-
Marketable Securities	250,000		
Cash Value Life Insurance	175,000	EQUITY	
Primary Residence	675,000	**TOTAL EQUITY**	**5,950,000**
Closely Held Companies	4,600,000		
TOTAL ASSETS	**5,950,000**	**TOTAL LIABILITIES & EQUITY**	**5,950,000**

David Gast

David Gast has been the Director of Operations of New Real Estate Capital in Bucharest, Romania since 2007. He is also the owner of two apartment buildings: a 500-unit building in Bronx, NY and a 54-unit building in Zurich, Switzerland.

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
David Gast	05/2017	2016	$44,071,000	$29,100,000	$14,971,000	$14,971,000	$1,000,000	$332,555	$87,725,000

5/25/2017

ASSETS		LIABILITIES	
Cash	1,000,000	**TOTAL LIABILITIES**	**29,100,000**
Primary Residence	1,600,000	EQUITY	
Real Estate Investments	41,471,000	**TOTAL EQUITY**	**14,971,000**
TOTAL ASSETS	**44,071,000**	**TOTAL LIABILITIES & EQUITY**	**44,071,000**

Bernard Fuchs

Bernard Fuchs founded Lenoxx Electronics Corp. in 1975 and served as its Chief Executive Officer from 1975 until 2007. Lenoxx was a contract manufacturer of electronics that at its peak generated over $500mln a year in revenues and serviced major retail outlets throughout the world, including Walmart USA and its worldwide subsidiaries. Under Mr. Fuchs' leadership, Lenoxx received the Vendor of the Year award from Walmart for eight years in a row, which recognizes vendors that supply quality merchandise and excellent service. Mr. Fuchs managed relationships with 25 factories in four countries (Japan, Korea, Taiwan and China) and administered over 60thd employees.

Since retiring from Lenoxx, Mr. Fuchs has diversified his personal portfolio by investing in numerous alternative asset funds and many projects, including real estate and several health care facilities. Mr. Fuchs' SNF acquisitions include Hopkins Center for Rehabilitation and Healthcare and Bensonhurst Center for Rehabilitation and Healthcare. Hopkins Center, formerly Bishop Mugavero Center for Geriatric Care is a 288 bed Skilled Nursing Facility located in Brooklyn, N.Y. and Bensonhurst Center, formerly Holy Family Home, is a 200 bed Skilled Nursing Facility located in Brooklyn, N.Y. He successfully streamlined operations to realize efficiencies and increase profitability at these homes.

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Bernard Fuchs	05/2017	2016	$82,408,697	$0	$82,408,697	$82,408,697	$1,758,956	$3,217,880	$148,344,000

ASSETS		LIABILITIES	
Cash	1,758,956	**TOTAL LIABILITIES**	-
Non-Readily Marketable Securities	31,296,101		
Residential Real Estate	6,000,000	EQUITY	
Health Facilities Interests	42,933,640	**TOTAL EQUITY**	**82,408,697**
Escrow Deposit for Facility Purchase	420,000		
TOTAL ASSETS	**82,408,697**	**TOTAL LIABILITIES & EQUITY**	**82,408,697**

Josh Farkovits
Josh Farkovits is a strategic healthcare investor and founding member/VP of Comprehensive Healthcare Management Services, LLC.

Mr. Farkovits' strategic vision in Healthcare Management and Investing arises from his varied and in-depth experience in establishing and strategically investing in successful healthcare businesses. Over the last 15 years, Josh Farkovits spearheaded the Prisons and Jails program for Chem RX Pharmacy, founded and built one of the most utilized multi-specialty medical centers for multiple ethic groups in Queens NY, and has managed and or invested in the immensely successful turnarounds of ailing medical transportation companies (RCA Medical Transportation) and skilled nursing facilities (Focus Utica, Millhouse Skilled Nursing, Friendship Ridge Nursing Home).

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Joshua Farkovits	07/2017	2016	$60,006,415	$38,007,137	$21,999,278	$21,999,278	$3,705,000	$3,443,013	$37,144,655

7/1/2017

ASSETS		LIABILITIES	
Cash	3,705,000	Notes Payable	104,000
Cash in Escrow		Mortgages Payable: Healthcare Facilities	36,753,157
Real Estate Owned	3,118,000	Mortgages Payable: Primary Residence	1,150,000
CVLI	150,000	**TOTAL LIABILITIES**	**38,007,157**
Health Facility Realty Interests	30,033,415	**EQUITY**	
RCA Ambulance	8,000,000	**TOTAL EQUITY**	**21,999,258**
EAS Lifestar	15,000,000		
TOTAL ASSETS	**60,006,415**	**TOTAL LIABILITIES & EQUITY**	**60,006,415**

Benjamin Landa
Benjamin Landa received a Bachelor's Degree in Liberal Arts at Adelphi University in 1979. He owns and operates twenty-three SNFs in the State of New York. Benjamin worked with the New York Department of Health on policy development to provide services to historically underserved populations. He was appointed by Governor Pataki in 1995 to serve as a member of the New York State Public Health Counsel.

Benjamin began working with Skilled Nursing Facilities in 1998. He has founded management companies for skilled nursing facilities, offering short and long term rehabilitation, as well as unique medical, nursing, and rehabilitative programs throughout New York City, Long Island, and Westchester.

PERSONAL FINANCIAL SUMMARY									
	Statement Date	Tax Return Year	Total Assets	Total Liabilities	Net Worth	Adjusted Net Worth	Liquidity	Net Income	Contingent Liabilities
Benjamin Landa	12/2016	2016	$312,554,014	$4,491,783	$308,062,231	$308,062,231	$60,728,972	$12,178,515	$990,853,588

12/31/16 PFS

ASSETS		LIABILITIES	
Cash & Marketable Securities	60,728,972	Mortgages Payable	4,491,783
Business & Investments	236,188,325		
Real Estate	15,636,717		
		TOTAL LIABILITIES	**4,491,783**
		EQUITY	
		TOTAL EQUITY	**308,062,231**
TOTAL ASSETS	**312,554,014**	**TOTAL LIABILITIES & EQUITY**	**312,554,014**

EXHIBIT 18

LABORATORY SERVICES AGREEMENT

THIS LABORATORY SERVICES AGREEMENT (this "Agreement") is entered into this 1st day of January, 2015 by and between ACM MEDICAL LABORATORY, INC., a New York corporation with an address at 160 Elmgrove Park, Rochester, New York 14624 ("ACM"), and Comprehensive at Orleans, LLC, with an address at 14012 Route 31, Albion NY 14411 ("Client").

WHEREAS, ACM is engaged in the business of providing certain laboratory testing services; and

WHEREAS, Client desires to contract with ACM for the performance of certain laboratory testing services, and ACM is willing to provide such services upon the terms and conditions set forth in this Agreement;

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, intending to be legally bound, hereby agree as follows:

1. Services.

(a) Upon request from Client, ACM shall perform the laboratory testing services described in Schedule A attached hereto (the "Services"). Client shall make all requests for Services on ACM's standard order forms or on such other forms or in such other manner as may be approved by ACM from time to time.

(b) ACM shall perform the Services in accordance with all applicable state and federal laws, rules and regulations, as the same may be amended from time to time. All Services will be performed by competent and appropriately trained personnel in accordance with ACM's customary laboratory testing procedures and protocols.

(c) Client acknowledges and agrees that the Services may be performed by any Affiliate (as defined below) or subcontractor of ACM, provided that ACM remains responsible for all Services performed by any such Affiliate or subcontractor of ACM. For purposes of this Agreement, "Affiliate" shall mean any entity controlled by, controlling, or under common control with ACM.

2. Fees and Payment Terms.

(a) As compensation for the Services provided by ACM hereunder, Client shall pay ACM in accordance with the fee schedule(s) set forth on or otherwise referenced within Schedule A attached hereto.

(b) ACM shall invoice Client monthly for the Services. Client shall be solely responsible for payment of all amounts due and owing to ACM pursuant to any invoice, and shall pay each invoice within sixty (60) days of the invoice date. All payments shall reference the applicable invoice number and shall be delivered to:

ACM Medical Laboratory, Inc.
P.O. Box 26290
Rochester, NY 14624
Attention: Accounts Payable

In the event that Client fails to pay any undisputed invoice when it becomes due, ACM may charge Client a monthly late fee in an amount equal to the lesser of (i) 1.5% of the total amount of the past due payment, or (ii) the maximum amount permitted by law. Client shall pay for any expenses incurred by ACM (including reasonable attorneys' fees) in connection with its collection of any undisputed amounts which are past due. Without prejudice to any other rights that ACM may have in the event of Client's failure to timely pay any invoice, ACM may, upon written notice to Client, immediately cease providing further Services (unless to do so would be unsafe or hazardous to any individual) until (i) Client has paid in full all outstanding invoice amounts due and owing hereunder, and (ii) Client has provided assurance of payment for future Services satisfactory to ACM, in ACM's discretion.

(c) If Client disputes any portion of an invoice, then Client shall provide written notice to ACM of such dispute within fifteen (15) business days of its receipt of such invoice and shall pay all undisputed amounts in accordance with Section 2(b) above. Any invoice which Client does not dispute within fifteen (15) days of its receipt thereof shall be deemed accepted. The parties shall use good faith efforts to reconcile any disputed invoice amounts as soon as practicable.

(d) For a term of twelve (12) months following the effective date of this Agreement, ACM agrees to charge and Client agrees to pay for the Services in accordance with the fee schedule(s) described on Schedule A. As of the first anniversary of this Agreement, ACM shall have the right to modify the fee schedule(s); provided, however, that (i) any such modifications will not exceed the lesser of (A) the net change during the same period in the Consumer Price Index for Medical Care Services as reported by the Bureau of Labor Statistics of the U.S. Department of Labor, and (B) five percent (5%), and (ii) ACM shall not modify the fee schedule(s) more than once every twelve (12) months. All fee increases shall become effective thirty (30) days after Client is notified in writing of such modification.

3. Supplies. ACM will provide supplies directly related to the collection of specimens for laboratory testing, at a quantity that is reasonable based upon the number of specimens sent to ACM for analysis. Any unique supplies such as specialized tubes or shipping and packaging material may be subject to an additional charge. Upon termination of this Agreement, all supplies shall be returned to ACM at Client's expense.

4. Interface. ACM agrees to pay for the cost of establishing an electronic interface between ACM and Client (such cost not to exceed $3,000); provided, however, that (i) should this Agreement be terminated at any time during the first twelve (12) months, unless due to an uncured breach by ACM or termination without cause by ACM, Client will be responsible for reimbursing ACM for the full amount of the actual costs incurred by ACM in setting up the electronic interface, and (ii) should this Agreement be terminated at any time following the first twelve (12) months but prior to the expiration of thirty-six (36) months, unless due to an uncured breach by ACM or termination without cause by ACM, the actual costs incurred by ACM in setting up the electronic interface will be amortized over three (3) years and Client will be responsible for reimbursing ACM for all amounts attributable to the period of time following the termination of this Agreement. In the event that Client is responsible for reimbursing ACM for any portion or all of the costs incurred by ACM in setting up the electronic interface pursuant to the terms of this Section 5, Client will reimburse ACM for such amounts within fifteen (15) days following ACM's request and provision of documentation reasonably supporting the interface costs incurred by ACM in setting up the electronic interface. Any and all additional interface costs including but not limited to interface maintenance fees, system upgrades, or other system requirements will be the sole responsibility of Client. Client is responsible for complying with all applicable laws, rules and regulations in connection with its access and utilization of patient test results via the electronic interface, including without limitation in accordance with the Health Information Portability and Accountability Act of 1996 and the regulations promulgated thereunder, each as amended from time to time, and any other laws, rules and regulations pertaining to the handling of personally identifiable information.

5. Term and Termination.

(a) The term of this Agreement shall commence on the date first set forth above and, unless terminated in accordance with Section 6(b) below, shall continue for a period of twelve (12) months (the "Initial Term"). At the end of the Initial Term, this Agreement shall automatically renew for an unlimited number of successive twelve (12) month terms (each a "Renewal Term") unless either party terminates this Agreement in accordance with Section 6(b) below. The Initial Term and any and all Renewal Terms are referred to collectively as the "Term".

(b) This Agreement may be terminated by either party hereto at any time, with or without cause, upon thirty (30) days prior written notice. In the event of a material breach of any term of this Agreement, the non-breaching party may send written notification to the breaching party setting forth the nature of such breach. The breaching party shall have ten (10) days from the date of receipt of such notice to cure the breach (the "Cure Period"). If the breaching party does not cure such breach to the reasonable satisfaction of the non-breaching party within the Cure Period, the non-breaching party may immediately terminate this

Agreement. Either party may terminate this Agreement, effective immediately upon written notice, if the other party hereto assigns this Agreement in violation of Section 16 below without the prior written consent of the other party hereto, or if the other party hereto files a petition or is subject to an involuntary petition filed against it under the U.S. Bankruptcy Code or any successor or comparable statute.

(c) Upon termination of this Agreement, the parties agree to wind down and transition the Services in an orderly manner and to preserve and protect the health and safety of any patient, and Client shall pay ACM, within thirty (30) days following the effective date of termination, any and all amounts due and owing to ACM for Services actually performed and documented expenses actually incurred up to the effective date of termination.

6. Change in Law or Regulation. The parties hereto acknowledge and agree that the fees to be paid by Client hereunder are based in part upon ACM's compliance with all federal, state and local statutes, laws, rules, regulations, guidelines and ordinances applicable to the Services. If there is a material change in any applicable law, rule or regulation that would make it commercially unreasonable for ACM to provide the Services at the agreed upon rates, ACM shall have the right to modify the rates or fees to be charged to Client for the Services, upon written notice to Client; provided, however, that Client shall have the right to terminate this Agreement upon written notice to ACM within thirty (30) days of such notice if it does not agree to accept such rate changes or fee increases.

7. Licensure. During the Term of this Agreement, ACM shall maintain any and all licenses, permits and certifications required by applicable law or regulation for the performance of the Services.

8. Disclaimer of Warranty. EXCEPT AS EXPRESSLY SET FORTH HEREIN, NO OTHER WARRANTIES ARE MADE BY ACM AND, TO THE FULLEST EXTENT PERMITTED BY LAW, ACM HEREBY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, OF ANY KIND, INCLUDING WITHOUT LIMITATION WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

9. Limitation of Liability. In the event that any Services are improperly or inadequately performed by ACM, Client's sole remedy and ACM's sole obligation with respect to such deficient Services shall be for Client to either (i) require ACM to re-perform such improper or deficient Services, at no additional charge to Client, or (ii) request a refund of all amounts paid to ACM for such improperly or inadequately performed Services. In no event shall either party be responsible for (i) any indirect, consequential, incidental, punitive or special damages (including without limitation damages for lost profits or revenue, loss of use, business interruption, loss of information, or for the procurement of substitute services) of the other party or of any third party, even if such party has been advised of the potential for such damages and whether such damages arise in contract, negligence, tort, under statute, in equity, at law or otherwise, or (ii) any damages in excess of the aggregate amount of fees paid to ACM under this Agreement during the prior twelve (12) months.

10. Indemnification. Subject to the limitations set forth in Section 10 above, the parties agree to the following indemnification obligations hereunder:

(a) ACM shall defend, indemnify and hold harmless Client and its employees, officers, directors, shareholders, agents, representatives, successors and assigns, from and against any and all third party claims, liabilities, costs, damages, suits, actions, debts, charges and expenses (including attorneys' fees, court costs and any amounts paid in settlement) that Client shall or at any time may sustain, arising out of or in connection with a breach of this Agreement by ACM or the negligent or intentionally wrongful acts or omissions of ACM; provided, however, that ACM shall not be liable for any damages, losses, costs or expenses to the extent attributable to the negligent or intentionally wrongful acts or omissions of Client.

(b) Client shall defend, indemnify and hold harmless ACM, its Affiliates, and their respective employees, officers, directors, shareholders, agents, representatives, successors and assigns, from and against any and all third party claims, liabilities, costs, damages, suits, actions, debts, charges and expenses (including attorneys' fees, court costs and any amounts paid in settlement) that ACM shall or at any time may sustain, arising out of or in connection with a breach of this Agreement by Client or the negligent or intentionally wrongful acts or omissions of Client; provided, however, that Client shall not be liable for any damages, losses, costs or expenses to the extent attributable to the negligent or intentionally wrongful acts or omissions of ACM.

11. Independent Contractors. ACM and Client hereby acknowledge and agree that the relationship created by this Agreement is that of independent contractors. Nothing contained in this Agreement shall be construed to constitute either party as an employee or agent of the other party hereto, nor shall either party have any authority to bind the other in any respect, it being intended that each party shall be an independent contractor responsible for its own actions.

12. Force Majeure and Delays. In the event that either party shall be delayed, hindered or prevented from the performance of any act required hereunder by reason of strike, lockouts, labor troubles, inability to procure materials, failure of power or restrictive government or judicial orders, or decrees, riots, insurrection, war, terrorism, Acts of God, inclement weather or other similar reason or cause beyond that party's control, then performance of such act (except for the payment of money owed) shall be excused for the period of such delay; provided, however, that if such delay continues in excess of thirty (30) days, the other party may terminate this Agreement without penalty.

13. Notices. Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be deemed to have been given and received (i) upon hand delivery, (ii) three (3) days after being sent by certified or registered mail, return receipt requested, or (iii) one (1) day after being deposited with a recognized overnight courier with confirmation of next day delivery, addressed as follows:

If to ACM:

ACM Medical Laboratory, Inc.
Attention: President
160 Elmgrove Park
Rochester, New York 14624
Fax: (800) 260-4051

If to Client:

Comprehensive at Orleans, LLC
Attention: William Gillick
14012 Route 31
Albion, NY, 14411

14. Entire Agreement; Hierarchy of Terms. This Agreement, together with Schedule A attached hereto and any additional schedules or exhibits attached hereto, constitutes the entire agreement between ACM and Client relating to the subject matter hereof, and supersedes all prior understandings and agreements relating to the subject matter hereof. This Agreement may not be amended, modified, supplemented or otherwise altered, except by a writing signed by the parties hereto. In the event of any conflict or inconsistency between any provision(s) of this Agreement and any schedule or exhibit attached hereto, the provisions of this Agreement shall govern and control with respect to any conflict or inconsistency with any schedule or exhibit, unless such schedule or exhibit expressly indicates an intent to supersede the provisions of this Agreement.

15. Assignment. Neither this Agreement nor any of the parties' respective rights or interests hereunder may be assigned without the prior written consent of the other party hereto; provided, however, that either party may assign this Agreement in whole in connection with the transfer or sale of all or substantially all of its assets or fifty percent (50%) or more of its equity interests, or its merger or consolidation with or into a third party, provided that any such assignee is not a direct competitor of the non-assigning party and such assignee agrees in writing to be bound by and comply with all of the terms and conditions of this Agreement. Any attempted assignment in violation of this Section 16 shall be deemed null and void and of no effect whatsoever.

16. Severability. The lack of enforceability or invalidity of any provision or provisions of this Agreement shall not render any other provision contained herein unenforceable or invalid, and the provision or provisions found unenforceable or invalid will be enforced to the maximum extent enforceable by law or equity.

17. Waiver. Any failure or delay on the part of ACM or Client in exercising its rights hereunder shall not operate as a waiver of such rights, nor shall a single or partial exercise preclude any further exercise of any right, power or privilege by either party.

18. Survival. The terms set forth in Sections 2, 4 (with respect to Client's obligation to return supplies upon termination), 5 (with respect to Client's obligation, if any, to reimburse ACM for interface costs upon termination), 6(c), 9, 10, 11, 14, 15, 17, 18, 19, 20 and 21, and the parties' respective obligations thereunder shall survive termination or expiration of this Agreement.

19. Non-Solicitation. Each party hereto hereby agrees that, during the term of this Agreement and for a period of one (1) year following the termination of this Agreement, it will

not directly solicit, recruit or hire any employee of the other party; provided, however, that the foregoing provisions will not prevent either party from conducting solicitation via a general advertisement for employment that is not specifically directed to any such employee or from employing any such person who responds to such general solicitation.

20. Governing Law. This Agreement shall be governed by, interpreted, construed and enforced in accordance with the laws of the State of New York, without giving effect to the conflicts of laws principles thereof.

21. Counterparts. This Agreement may be executed in more than one counterpart, each of which shall be deemed an original and all of which, when taken together, shall constitute one and the same instrument.

[Remainder of page intentionally left blank. Signature page follows.]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be signed as of the date first set forth above.

ACM MEDICAL LABORATORY, INC.

By: _____
Angela Panzarella
President

COMPREHENSIVE at ORLEANS, LLC

By: _____
Name: David Gast
Title: member

SCHEDULE A

Description of Services and Fee Schedule(s)

FEE SCHEDULE	**RATE**
1. Laboratory Testing for Medicare Part A	2012 Medicare Fee Schedule

Duties of Client

A. Client agrees to comply with ACM's specimen storage and collection requirements as set forth in the ACM Reference Manual.

B. Client will provide ACM personnel with access to parking, while such personnel are providing services on Client's premises. In addition, Client will grant ACM personnel access to all of its employee facilities while such personnel are in Client's facility on ACM business; provided, however, that such ACM personnel are required to comply with Client's policies and procedures in their enjoyment of such facilities.

C. Client will provide ACM with all documentation required for ACM to properly invoice Client, Clients' patient, Medicare, or any other insurer or other third party responsible for payment for services rendered. This documentation will include signed orders or, if utilized, requisition forms signed by the physician or qualified non-physician practitioner who ordered the service. The documentation shall also include all billing information, including patient name, Medicare or Medicaid number, ICD-9 diagnosis code(s), narratives, date of birth, insurance information and any other information required by ACM and/or any applicable law, rule or regulation to properly bill for services rendered. ACM shall not be required to perform clinical laboratory testing or other services hereunder unless it receives the documentation and information necessary to properly perform and bill for services rendered.

   In the event that signed orders and/or signed requisition forms and any other information or documentation required or requested from Client by ACM to properly invoice Client' patient, Medicare or any other insurer or other third party responsible for payment for services rendered hereunder are not provided by Client within thirty (30) days following ACM's written request therefore, then ACM shall have the right, exercisable in its discretion, to invoice Client directly and Client agrees to pay such amount in accordance with the terms of this Agreement.

D. It shall be the responsibility of Client to assure that:

   1. All tests ordered are medically necessary to treat or diagnose a patient;
   2. Access to documentation supporting medical necessity is available;

3. Diagnosis information is available to support each order;

4. The ordering physician understands the implications of ordering a customized profile;

5. Each standing order is confirmed in writing by Client;

6. Advance Beneficiary Notices are signed by residents or their authorized representatives when there is reason to believe that Medicare may deny payment for a particular service as not being reasonable and necessary, and Client assumes any and all responsibility for the appropriate use of Advance Beneficiary Notices;

7. Standing orders meet Medicare requirements, including that the attending physician has specifically ordered the test, for a defined period and frequency, and that the tests are medically necessary and do not violate frequency limitations;

8. In the event Medicare denies payment for tests ordered, and performed by ACM as ordered, Client will be responsible for payment to ACM at the rates set forth in the Fee Schedule contained in Section II of this Agreement;

9. In the event that any other payer (other than Medicare) denies payment for tests ordered, and performed by ACM as ordered, ACM may bill a secondary insurance, if it exists; and

10. Client retains professional and administrative responsibility for providing services hereunder that are timely and that meet applicable professional standards and principles

Duties of ACM

A. ACM shall be responsible for quality control of each service it provides, in accordance with the requirements of the New York State Clinical Laboratory Evaluation Unit and the ACM Quality Assurance Program. A copy of the ACM Quality Assurance Program is available upon Client's request.

B. ACM will perform only those tests ordered in writing by the attending or consulting physicians of Client's patients. ACM is not responsible for test selection, patient care plans, final diagnosis or compliance with laws other than those governing the performance of ACM's clinical laboratory services or those relating to the confidentiality of medical records under CLIA, HIPAA and/or other applicable laws or regulations.

C. Upon the written request of the attending physician or Client, ACM will provide ancillary phlebotomy and courier services related to obtaining and transporting specimens requested by Client's patients' attending or consulting physicians. Any changes or modifications to such ancillary phlebotomy and/or courier services shall be mutually agreed upon in writing. As such, ACM will provide phlebotomy services one draw day per week and daily courier stops for routine specimen pickup. Any additional ancillary service arrangements may be confirmed by contacting ACM at (585) 429-1237. Please note that STAT testing requests will be transported to ACM for testing by ACM couriers but will be collected by the staff at Client.

D. ACM will provide all equipment, supplies, materials, personnel and supervision necessary to fulfill its obligations hereunder. If Client elects to stock certain supplies in order to facilitate the collection of specimens by its personnel and/or physicians, such supplies shall comply with ACM's requirements to assure compatibility with ACM's testing and processing equipment. Upon termination of this Agreement, any and all supplies, equipment and materials are to be returned to ACM.

E. In the event that specimens are obtained by parties other than ACM personnel, the storage requirements and minimum specimen size required for performance of each service to be provided by ACM hereunder are set forth in the ACM Reference Manual. ACM will not accept improperly stored specimens or specimens of less than the minimum size. ACM will promptly notify Client when it is unable or unwilling to perform a requested service for the reasons of improper storage or insufficient quantity supplied. Client acknowledges that ACM's refusal or inability to perform any clinical laboratory services requested by the attending or consulting physicians of Client's patients by reason of any party's non-compliance with ACM's storage and/or minimum specimen size requirements shall not constitute a breach or default of this Agreement or be deemed cause for termination of this Agreement by Client.

F. In the event that a specimen is lost, destroyed or otherwise becomes unavailable or unsuitable for service processing for any reason whatsoever, ACM will notify Client promptly. ACM's responsibility, if any, for lost, destroyed or otherwise unavailable or unsuitable specimens will be limited to its direct costs incurred in obtaining a replacement specimen, including transportation costs not to exceed $30.00, and ACM will not be liable for any additional direct or indirect costs, fees or expenses.

G. Reports of the clinical laboratory services requested by Client's patients' attending or consulting physician shall be produced by ACM and promptly provided to the physician requesting performance of such services. A copy of each such report shall also be promptly provided to Client for inclusion in the patients' medical record.

H. ACM agrees to maintain the confidentiality of information contained in the medical records of Client's patients and, except for the required dissemination of such records to authorities, not to disclose such information without the written consent of the individual authorized to release such records, or as required by state and/or federal law, including without limitation CLIA, HIPAA or other applicable laws or regulations.

I. ACM agrees that before its personnel enter the premises of Client to render any services pursuant to this Agreement, such personnel will have received either a negative PPD test result within one year of such assignment or a chest x-ray negative for tuberculosis infection within two years before such assignment.

J. Those clinical laboratory services that may be requested by the patient's physician are listed in the ACM Reference Manual. ACM agrees to accept payments for such services in accordance with applicable federal and state laws and, when applicable, its provider agreements with patients' third party payers. The provision of such services to patients

without third party coverage shall be at the rates and in accordance with the terms set forth in Schedule A of this Agreement. ACM reserves the right to amend from time to time its schedule of services, in accordance with any applicable regulatory requirements, upon prior notice to Client.

K. In accordance with federal and New York State law, ACM shall be directly responsible for billing and collecting payment from Medicare, Medicaid, third party insurance or third party payers to whom or which Client does not provide consolidated billing.

EXHIBIT 19

HEALTHCARE STAFFING AGREEMENT

This Healthcare Staffing Agreement together with Attachment 1 hereto and all applicable Service Line Exhibits (collectively, the "Agreement") is entered into by and between **Villages of Orleans** ("Client") and AMN Healthcare, Inc. ("Agency") on **January 28, 2016** for the purpose of using healthcare clinicians ("Clinicians") to provide temporary professional services at Client's facility(ies).

1. **DESCRIPTION OF SERVICES.** Agency will use its best efforts to recruit qualified Clinicians to staff Client's facility(ies) from Agency and/or Agency's direct and indirect subsidiaries in accordance with Client's specifications. It is Agency's policy not to use subcontractors. The one or more attached service line exhibits ("Service Line Exhibit(s)") set forth the specific services to be furnished by Agency for the applicable service line, together with current fees for these services and other terms specific to such service line. Client represents, warrants and covenants that it (A) has obtained and will keep current all licenses, permits and authorizations necessary to conduct its business and to utilize the Clinicians in accordance with all applicable laws, rules and regulations, and (B) shall provide and be responsible for all oversight of Clinicians in connection with the temporary professional services provided by Clinicians for Client.

2. **COMPENSATION TO AGENCY.** Client agrees to pay for services rendered under this Agreement in accordance with the Service Line Exhibit(s), plus all applicable federal, state and local taxes that may be payable by Agency, including but not limited to, sales/use tax, excise tax and gross receipts tax. Should Agency be required to pay a Clinician any wage/hour penalty as required by federal or state law, such penalty shall be billed to Client at the regular rate. The parties acknowledge that they have a reimbursement arrangement with respect to housing and meals. The reimbursement amount is included in the fee Client pays for services, except as otherwise specifically stated herein. Agency will provide substantiation of the reimbursement amount. Amounts reimbursed by Client may be subject to tax deduction limitations.

3. **INVOICING.** Invoices will be rendered weekly and delivered via email or a web-based application (and Client and Agency shall cooperate to allow Client to obtain invoices in such manner) to the designation set forth in the section entitled "Notices" below. If Client requires Agency to use a non-electronic method of invoicing, then a $5.00 per non-electronic invoice fee shall apply. Payment by Client shall be due within 30 days of the invoice date and shall be paid by check or EFT. Credit card payments shall not be permitted without Agency's written consent, which may be withheld in its sole discretion. Agency may impose a finance charge of 18% per annum (or the maximum charge permitted by law, if less) to all outstanding past due amounts. Information appearing on the invoice shall be deemed accurate and affirmed by Client unless Client notifies Agency in writing, specifying the particular error(s), omission(s) or objection(s) within 45 days of the invoice date. Failure to notify Agency within that time shall constitute a waiver by Client of any objection thereto.

4. **FINANCIAL STATEMENTS.** If Client is past due on any invoice by 45 days or more, it shall, upon Agency's request, promptly provide its financial statements (including its balance sheet, income statement and statement of cash flows) for its most recently completed fiscal year and for all interim periods since such fiscal year (collectively, "Financial Statements"). Alternatively, Client may immediately bring its account current. Additionally, if Client reaches an account receivable balance of $500,000 or more, upon Agency's request, but no more than quarterly, Client shall promptly provide its Financial Statements and other financial information Agency reasonably requests.

5. **GOVERNMENT MANDATED COST INCREASES.** If at any time during the term of this Agreement, Agency is required to increase its employees' compensation (due to increase in minimum wage rates or mandatory benefits requirement), or incurs an increase in its compensation costs as a direct result of any law, determination, order or action by a governmental authority or government insurance benefit program, Client agrees that Agency may increase the bill rates proportionately so as to place Agency in the same position it was in prior to such law, determination, order or action. Client shall pay such increased bill rates upon Agency's provision of 30 days notice of such increase.

6. **MEDICARE ACCESS.** In compliance with Section 420.302(b) of the Medicare regulations, until the expiration of four years after the furnishing of the services provided under this Agreement, Agency will make available to the Secretary, U.S. Department of Health and Human Services, the U.S. Comptroller General, and their representatives, this Agreement and all books, documents and records necessary to certify the nature and extent of the costs of those services.

7. **EQUAL EMPLOYMENT OPPORTUNITY POLICY.** Both parties acknowledge that they are equal opportunity employers and agree that they do not and will not discriminate against, harass, or retaliate against any employee or job applicant on the basis of race, color, religion, sex, national origin, age, disability, veteran status, sexual

orientation, gender identity, or any other status or condition protected by applicable federal, state or local laws. Client will promptly investigate allegations of discrimination, harassment and retaliation and will report to Agency any suspected discrimination, harassment and/or retaliation either by or against Clinicians immediately.

Client shall indemnify Agency for all costs, liabilities or losses associated with defending any charge, complaint, claim, cause of action or suit (hereinafter collectively referred to as "claim(s)") by (A) any governmental or administrative agency and/or (B) any Clinician or anyone acting on his/her behalf, in which Client's action/inaction has given rise to, in whole or in part, the underlying claim. This may include, but is not limited to, claims for breach of contract, defamation, invasion of privacy, intentional or negligent infliction of emotional distress, wrongful discharge, discrimination, harassment, retaliation, or violation of any federal, state or other governmental statute or regulation.

8. **NOTICES.** All notices, demands, requests or other instruments that may be or are required to be given hereunder ("Notices") shall be in writing and sent to the addresses set forth below (for Client under "Notices (Other than Invoices/Billing)"), by hand delivery, first class, certified mail – return receipt requested or via overnight courier, postage prepaid. Invoices and billing items for Client shall be sent to the address set forth below and as provided in the section entitled "Invoicing" above.

AGENCY President, Travel Nursing
12400 High Bluff Drive, Suite 100
San Diego, California 92130

CLIENT	NOTICES (OTHER THAN INVOICES/BILLING):	INVOICES AND BILLING:
	X_____ Client Designated Contact Name	X_____ Client Designated Contact Name
	X_____ Client Designated Client Name	X_____ Client Designated Client Name
	X_____ Client Designated Address	X_____ Client Designated Address
	X_____ Client Designated City, State, Zip	X_____ Client Designated City, State, Zip
	X_____ Client Designated Email Address	X_____ Client Designated Email Address

The designations for Notices provided herein are conclusively deemed to be valid, and notice given in compliance with this paragraph shall be conclusively presumed to be proper and adequate. Either party may from time to time add or change its notice designation above in a writing given to the other party.

9. **ENTIRE AGREEMENT; ATTORNEYS' FEES; GOVERNING LAW.** This Agreement (including Attachment 1 and each executed Service Line Exhibit) contains the entire agreement between the parties and supersedes all prior oral and written agreements, understandings, commitments and practices between the parties. No amendments to this Agreement (including a Service Line Exhibit) may be made except by written mutual agreement. In the event of a conflict between this Healthcare Staffing Agreement (or Attachment 1), on the one hand, and a Service Line Exhibit on the other hand, this Healthcare Staffing Agreement (or Attachment 1) shall control unless the conflicting provision in the Service Line Exhibit explicitly indicates the intent for such provision to supersede a specific provision in this Healthcare Staffing Agreement (or Attachment 1). In the event that any action is brought to enforce or interpret this Agreement or any part thereof, the prevailing party shall recover its costs and reasonable attorneys' fees in bringing such action. In the event of non-payment by Client, Client shall pay all costs incurred by Agency in collecting delinquent amounts, including collection agency fees. This Agreement shall be governed by and construed in accordance with the laws of the State of California without regard to its conflict of laws rules. The parties consent to the exclusive jurisdiction of the state and federal courts located in the County of San Diego, California for any action arising under this Agreement.

10. **INSURANCE AND SAFETY LAWS.** At Client's request, Agency will provide certificates evidencing its worker's compensation, general liability and professional liability insurance coverage. Client accepts responsibility for compliance with all relevant safety and health laws and regulations during the period of a Clinician's assignment under Client's supervision, including but not limited to Joint Commission regulations relating to orientation and evaluation and HIPAA regulations. While Agency will give each Clinician a safety and standards manual relating to safety, universal precautions, occupational exposure to bloodborne pathogens, other safety issues and HIPAA regulations, Client will also provide each Clinician with all necessary site-specific training, orientation, equipment

and evaluations required by federal, state or local occupational safety laws or rules, including Joint Commission and HIPAA, for members of Client's workforce. Further, Client will only assign Clinicians to work in the clinical specialty areas in which they are professionally qualified and oriented to work. In the event of any sentinel event or actual or threatened claim arising out of or relating to the acts or omissions of Clinician, Client shall provide Agency written notice of such claim immediately and, in no event more than 30 days after Client knew, or reasonably should have known, of such claim.

11. **CONFIDENTIAL INFORMATION.** Each Party shall keep confidential all Confidential Information of the other party ("owning party"), and shall not use or disclose such Confidential Information either during or at any time after the term of this Agreement, without owning party's express written consent, unless required to do so by law, court order or subpoena, in which case a party shall not disclose such information until it has provided advance notice to owning party such that owning party may timely act to protect such disclosure. For purposes of this provision, "Confidential Information" means non-public information about either party or its employees that is disclosed or becomes known to the other party as a consequence of or through its activities under this Agreement, including, but not limited to, matters of a business nature, such as Clinician and prospective Clinician names and information, bill rates and the terms of this Agreement, compensation and benefits packages and structure, hiring decision-making process, hiring needs and/or requests for placement, costs, profits, margins, markets, sales, business processes, information systems, and any other information of a similar nature. Client agrees to use appropriate security measures to protect Agency and its subsidiaries' employee, client and/or Clinician personal information from unauthorized access, destruction, use, modification or disclosure in accordance with all federal and state privacy laws.

12. **CONSENT TO FAX.** In order to ensure that Agency is in compliance with state and federal law, Client hereby expressly grants permission to Agency to send all facsimile communications to any Client location.

13. **TERM.** The term of this Agreement shall be for a period of one year, and this Agreement will renew automatically for successive one year periods. Either party may terminate this Agreement upon the other party's material breach and failure to cure within 30 days, or at any time upon provision of 30 days written notice to the other party; provided, however, all Clinicians currently confirmed for an assignment, or at work on an assignment, will be permitted at Agency's option to complete their assignments under the terms of this Agreement. This Agreement shall be binding on and inure to the benefit of the successors and/or assigns of Agency.

14. **SEVERABILITY.** If any provision herein is held to be contrary to law, such provision will be deemed valid only to the extent permitted by law. All other provisions shall continue in full force and effect.

15. **NON WAIVER.** Agency's failure to require performance of any provision of this Agreement shall not affect its right to require performance at any time thereafter, nor shall Agency's waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default.

AGREED AND ACCEPTED

Villages of Orleans	**AMN HEALTHCARE, INC.**
By: D. Gast	By:
david gast	
Name	Name
member	
Title	Title
02 / 18 / 2016	
Date	Date

EXHIBIT 20

SERVICE AGREEMENT
BETWEEN
PREVENTIVE DIAGNOSTICS INC.
And
The Villages of Orleans Health & Rehabilitation Center

This Agreement is entered into this First (1st) of November 2015 by and between Preventive Diagnostics Inc. (PDI) with offices located at 544 Park Ave Brooklyn NY, 11205 and The Villages of Orleans Health & Rehabilitation Center (Facility) located at 14012 Route 31, Albion, NY 14411

BACKGROUND

PDI is engaged in the business of providing medical testing services, including Portable Diagnostic Radiology Services onsite in nursing homes, hospitals, and other institutions. The Facility desires to have PDI provide these services to the Facility's patients. PDI wishes to provide such services.

In light of the foregoing and in consideration of the mutual covenants promises and agreements herein contained, the parties agree as follows:

Services

1- Preventative Diagnostics Inc. will provide medical testing services to, including Portable Diagnostic Radiology Services onsite at the Facility, residents and patients of the Facility only upon presentation of a written order from the patient's duly licensed and authorized physician to PDI All imaging exams will be interpreted by a Board certified, duly licensed and qualified Radiologist.

a. PDI will provide and supervise all qualified technical personnel necessary to administer the services. All personnel are nationally registered and New York State licensed to perform radiologic technical services.
b. PDI will provide all testing equipment, including transport of such equipment to and from the Facility, set up and dismantling, and all other needs necessary to administer the services to Facility resident's onsite in the Facility.
c. Facility will furnish at no charge to PDI appropriate space on the Facility's premises at which PDI will perform said medical testing to the Facility's residents. The Facility must also provide the use of its utilities at no expense to Preventive Diagnostics Inc.

2- X-ray and E.K.G. services are performed between the hours of 7 am and 10 pm. Routine Ultrasound services are performed Monday thru Friday during the hours of 9 am – 6 pm. All STAT exams are performed with-in 4 hours of request. PDI maintains a 24 hour a day 7 days a week online, voicemail, and fax service for scheduling purposes. Preventive Diagnostics Inc.'s services are available 365 days a year.

3- PDI is retained to provide the services as an independent contractor. It is mutually understood and agreed that the Facility should neither have nor exercise the power to direct, control, or supervise the services of PDI to perform hereunder. Employees of PDI are not and will not hold themselves out to be employees of the Facility.

Payment

4- For all patients designated as Medicare Part A or whose stay is covered by an "all inclusive arrangement" between Facility and Insurance Carrier, PDI will invoice Facility for all imaging services provided. PDI will invoice Facility monthly according to the agreed upon fee schedule as outlined in "Exhibit A". Facility agrees to abide by its obligations to accurately report amounts charged by PDI in cost reports filed by Facility and other disclosures made by Facility to third party regulatory authorities.

The Facility will provide PDI with a listing of patients by the first (1^{th}) of each month by fax or email to PDI's billing department at 718-228-9318. PDI will provide Facility with an invoice for services performed on said patients by the tenth (10^{th}) of each month.

Facility agrees to use it best efforts to provide PDI with accurate and timely billing information so that PDI can process patient charges to Facility or appropriate insurance carrier. Facility shall be responsible for obtaining all pre-authorizations required by third party carriers prior to PDI's performance of an exam. Failure to obtain and provide pre-authorizations will subject Facility to responsibility of all charges associated with the applicable exam.

60 DAYS

Facility agrees to pay each PDI invoice in full within thirty (30) days of invoice date. Facility agrees that any Facility requested changes to an invoice (i.e. change in patient insurance status) must be submitted to PDI within thirty (30) days of service.

PDI and Facility will comply with all applicable laws including, but not limiting to, all Medicare and Medicaid statues, rules, regulations, and manuals, and with all applicable agreements and policies of third party payers (i.e. insurance carriers), in connection with Facility's billing for services provided by PDI.

5- PDI will invoice Medicare, Medicaid or appropriate insurance carrier for all services provided to patients not covered under Medicare Part A or an "all inclusive arrangement" between Facility and Medicare, managed care organization, or private insurance carrier.

Term

6- The term of this Agreement shall commence on the date first written above and shall continue in full force for one (1) year unless sooner terminated as provided herein. Thereafter, this Agreement will automatically renew for successive one (1) year periods unless terminated as set forth below.

a. If either party with or without cause notifies the other party in writing at least thirty (30) days prior to the intended effective date of termination.
b. This Agreement will automatically terminate upon the loss by the Facility or PDI of any required Federal, State or local licensure.

Insurance

7- PDI will obtain and maintain Professional and General Liability insurance coverage for officers, employees and equipment with limits of $1,000,000/$3,000,000 and will provide Facility with an Accord Certificate of Insurance upon execution of this Agreement, naming Facility as Certificate Holder.

Indemnification

8-

A- PDI will defend, indemnify and hold harmless Facility, its officers, employees, agents, affiliates and representatives from and against any and all damage, expense (including the cost of reasonable attorneys' fees and professional fees), causes of action, suits, claims, penalties, judgments and/or liabilities incurred by reasons of any breach of this Agreement by PDI, its officers, employees, agents, affiliates or representatives or any acts or omissions directly or indirectly caused by, arising out of, or attributable to any claim of gross negligence or intentional harm with respect work or acts performed or failed to be performed pursuant to this Agreement.

B- Facility will defend, indemnify and hold harmless PDI, its officers, employees, agents, affiliates and representatives from and against any and all damage, expense (including the cost of reasonable attorneys' fees and professional fees), causes of action, suits, claims, penalties, judgments and/or liabilities incurred by reasons of any breach of this Agreement by Facility, its officers, employees, agents, affiliates or representatives or any acts or omissions directly or indirectly caused by, arising out of, or attributable to any claim of gross negligence or intentional harm with respect to any work or acts performed or failed to be performed pursuant to this Agreement.

Compliance with Laws

9- **PDI** and the Facility shall comply with all applicable provisions of law relating to registration, licensing, and regulation of PDI or the Facility in connection with the services. Notwithstanding any other provision of this agreement, the Facility remains responsible for ensuring that any services provided to residents pursuant hereto comply with all pertinent provisions of Federal, State and local statutes, rules and regulations. PDI will cooperate fully with the Facility in this regard. PDI will comply with all pertinent provisions of Federal, State and local statutes, rules and regulations.

Confidentiality

10- Subject to paragraph 11 below, the parties hereto agree that the terms of this agreement constitute valuable proprietary information relating to the services provided by PDI which shall be treated as confidential information and shall not be disclosed at any time, whether before, during or after the term of the Agreement, to any third party, except to the extent disclosure is required pursuant to court order, statute or regulation or by any State Agency having jurisdiction over the Facility or PDI.

Books and Records Keeping

11- To the extent that Section 952 of the Omnibus Reconciliation Act of 1980 (the "Act") and the regulations promulgated there under (42 C.F.R. Section 402.300-.304), as amended from time to time and any successors thereto are applicable to any services rendered pursuant to this Agreement, the Facility and PDI shall each, until four (4) years after the date of the services provided, comply with requests for access by the Comptroller General of the United States, the Secretary of Health and Human services and their duty appointed representatives, in accordance with Section 952 of the Act, to this Agreement as well as to the books, documents and records of the Facility and PDI respectively, which are necessary to verify the cost of such services.

Miscellaneous

12- This Agreement may not be assigned, in whole or in part, by either party. This Agreement is executed, delivered and intended to be performed in the State of New York and shall be governed by, interpreted and construed in accordance with the laws of the State of New York. This Agreement shall be binding upon, and inure to the benefit of and be enforceable by the parties hereto and their respective legal

representatives, successors, assigns, subject to the prohibition on assignment in this section. This Agreement shall be interpreted with its plain meaning and not for or against any party hereto. All captions and herein are for organizational purposes only and not intended to limit the meaning of anything herein or to have independent legal meaning.

13- Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payor, or federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, limits, restricts or in any way substantially changes the method or amount of reimbursement for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, limitation, restriction or change.

14- If any paragraph, portion, section, subparagraph, sub-portion or subsection of this Agreement shall be determined to be unenforceable, illegal or invalid for any reason and in any respect, it shall not affect the remainder of this Agreement, which shall be and remain binding and effective as against all parties hereto.

15- A waiver by any party to this Agreement for a breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach of any other provision of this Agreement. This Agreement contains the entire agreement between the parties hereto to its subject matter, and this Agreement supersedes all prior negotiations, understandings and agreements whether oral or written between the parties hereto with respect to its subject matter. This Agreement may not be amended, terminated (except as provided in Section 6 hereof) or modified orally by any course or conduct or usage of trade, and may only be amended by the mutual written agreement of the parties hereto. Any references to this Agreement shall be deemed to include all renewals hereof.

16- PDI and any subcontractor of PDI shall cooperate with the Facility in the event that any third party payer, including the Medicare or Medicaid program, conducts and audit or otherwise requests documentation regarding services/supplies provided by PDI or its' subcontractors.

17- PDI and its subcontractors will notify the Facility of imposition of any remedies or sanctions, including termination or changes in status of the Medicare and or Medicaid program participation imposed by the OIG or State Medicaid agency and of the initiation of any audit of investigation of PDI or its subcontractors by any such agency.

18- The Facility agrees it shall not employ, either directly or indirectly, at any time during the term of this agreement or during the six month period after termination of this Agreement, any technical staff who provides the services as employees of PDI pursuant to this agreement.

19- Pursuant to Federal and State Law, the parties hereto agree there shall be no discrimination against anyone because of race, color, creed, age, national origin, marital status, sexual preference, sex, sponsor, blindness, disability or handicap.

20- Any notice required or permitted to be given under this Agreement shall be in writing and shall be deemed given when deposited, if sent by certified mail, return receipt requested, to the address of each party set forth at beginning of this Agreement.

IN WITNESS WHEREOF, the parties have executed the Agreement by their acts of their authorized officers on the date set forth below.

FACILITY: **The Villages of Orleans Health & Rehabilitation Center**

By: SAM HARBER

Signature: _____ Date: 11/25/15

Title: CEO

PROVIDER: **Preventive Diagnostics Inc.**

By: Mark Taubor, Executive Director

Signature: _____ Date: 11/25/15

EXHIBIT A

Fee schedule is according to the Medicare fee schedule, A twenty (20) percent discount will be applied for payments received with-in ~~30~~ 60 days of invoice.

EXHIBIT 21

(AB7776

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 05-06-2014

Employer Identification Number: [redacted]

Form: SS-4

Number of this notice: CP 575 G

COMPREHENSIVE AT ORLEANS
EPHRAIM M LAHASKY SOLE MBR
150 MOTOR PKWY STE 401
HAUPPAUGE, NY 11788

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [redacted]. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

A limited liability company (LLC) may file Form 8832, *Entity Classification Election*, and elect to be classified as an association taxable as a corporation. If the LLC is eligible to be treated as a corporation that meets certain tests and it will be electing S corporation status, it must timely file Form 2553, *Election by a Small Business Corporation*. The LLC will be treated as a corporation as of the effective date of the S corporation election and does not need to file Form 8832.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.

* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.

* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is [redacted]. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

E1534800005061

(1) ETIN [redacted] 12/10/15

(2) BILLING SERVICE NAME (IF APPLICABLE) _____

eMedNY/MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER BILLING MEDICAID

(3) As of (date) **11/09/2015**, all claims submitted electronically or on paper to the State's Medicaid fiscal agent, for services or supplies furnished

(4) by (provider name) COMPREHENSIVE AT ORLEANS LLC

(5) (10-digit National Provider ID (NPI) -- REQUIRED unless exempted from NPI) **1245638139**

(6) (8-digit Medicaid Provider Number -- If NPI exempt) **00308998**

will be subject to the following certification.

I am (or the business entity named in this form of which I am a partner, officer, or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the persons providing services, care and supplies have the necessary licensing, certification, training and experience to perform the claimed services; I have reviewed these claims; I (or the entity) have furnished or caused to be furnished the care, services, and supplies itemized and done so in accordance with applicable federal and state laws and regulations; I have read the eMedNY Provider Manual and all revisions thereto; all claims are made in full compliance with the pertinent provisions of the Manual and revisions; all claims for care, services and supplies provided at the order of another professional have to the best of my knowledge been ordered by that professional in bona fide compliance with the procedures set forth in the manual and revisions. All care, services and supplies for which claim is made are medically necessary for the treatment of the named recipient, the amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any other source other than the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL STATEMENTS, DATA AND INFORMATION TRANSMITTED ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE FINED AND/OR PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY VIOLATION OF THE TERMS OF THIS CERTIFICATION, INCLUDING BUT NOT LIMITED TO FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding these claims and payment therefor shall be promptly furnished upon request to the local Department of Social Services, the State Department of Health, the Office of the Medicaid Inspector General, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirement of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to claims submitted under this agreement to enable its automated processing, subject to reversal by the provider, and (2) accept the claim under this agreement as original evidence of care, services and supplies furnished.

In submitting claims under this agreement I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health and the Office of the Medicaid Inspector General as set forth in statute or title 18 of the Official Compilation of Codes, Rules and Regulation of New York State and other publications of the Department, including eMedNY Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of the law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or my entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I UNDERSTAND THAT MY SIGNATURE HEREON THE ABOVE CERTIFICATION WILL APPLY TO ALL CLAIMS SUBMITTED ELECTRONICALLY OR ON PAPER, USING MY (OR THE ENTITY'S) NPI OR MEDICAID PROVIDER IDENTIFICATION NUMBER. THIS CERTIFICATION REMAINS IN EFFECT AND APPLIES TO ALL CLAIMS UNTIL SUPERSEDED BY ANOTHER PROPERLY EXECUTED CERTIFICATION STATEMENT.

PLEASE DO NOT STAPLE OR WRITE IN BAR CODE AREA

(7) (Signature) _____ (8) (Date) 12/1/15

(9) (Print Name and Title) Ephram Mordy Lahasky

(10) (Telephone #) [redacted] (11) (eMail, if available) [redacted]

STATE OF New York
COUNTY OF Orleans

(12)

On this 1st day of December, 2015, before me personally came

Ephram Mordy Lahasky to me known and known to me to the individual described in and who executed the foregoing instrument, and (s)he acknowledge to me that (s)he executed the same.

ANNETTE BARONE
Notary Public - State of New York
No. 01BA5013089
Qualified in Niagara County
My Commission Expires July 15, 2019

Annette Barone
NOTARY PUBLIC

[redacted]

E1534800005061 eMEDNY-490600 (12/10)

EXHIBIT 23

acceptable 9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	07/31/2015

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

(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) COMPLETE DATE
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #NY00166235) completed on 7/31/15, the facility did not store, prepare, distribute, and serve food under sanitary conditions. One (Main Kitchen) of one kitchen observed for food storage and preparation had issues involving mold on food items, storage racks, and the ceiling of the walk-in cooler; storage of undated, outdated, unlabeled, and uncovered food items in the walk-in cooler; suboptimal temperatures in the walk-in cooler; soiled floors; flies; freezer fans and food items that had a coating of ice in the walk- in freezer; steam table pans that had dried food on the bottom; wet pans that were stacked and stored for use; and bearded dietary staff who were not wearing beard covers during meal preparation in the kitchen. In addition, two (Autumn View, Village) of two unit kitchenettes had issues involving unlabeled and undated food stored in the refrigerators; a dirty refrigerator/freezer, floor, and counter top; employee food stored in resident refrigerators; and an ice machine with lime build up. This was widespread with no actual harm with potential for more than minimal harm that is not	F 371	The following has been accomplished for the deficiency cited: 1a)The entire walk-in cooler was emptied and properly cleaned with bleach based solution b)All open, unlabeled or expired food items were immediately discarded. c)All unlabeled items in the refrigerator located in the cook's area were immediately discarded The following corrective action has been implemented to identify other areas in the facility that have the potential to be affected by this practice: -Weekly audit of all refrigeration equipment to ensure cleanliness. -Development and implementation of ongoing cleaning schedule to ensure compliance. The following systemic changes implemented to ensure compliance: -Results of weekly audits and cleaning schedule will be provided and reviewed in the facilities Quality assurance monthly meeting -The Food Service Director will be responsible for the implementation, monitoring and evaluation of this system 2a)The walk-in cooler door was closed an temperature stabilized. All items identified were immediately discarded. The ice build-up on the walk-in freezer was remover by the food service director. b) The temperature log has been adjusted to reflect specifically which refrigeration unit the specific log is for. The following corrective action has been implemented to identify other areas that	08/24/2015

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

Electronically Signed | 08/21/2015

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F 371	Continued From page 1 immediate jeopardy. The findings are: 1. Observation of the Main Kitchen on 7/30/15 , between 8:20 AM and 9:15 AM revealed the following concerns: a.) A build up of mold build-up was observed in the walk-in cooler. The mold was on the opposite wall of the cooling unit; on an approximately 2' (feet) x 2' area of the ceiling by one of the sprinkler heads; on the cooling unit; around the fan area; and on seven green wire storage racks. Spots of mold were found on the outside of 11 opened food containers, including containers of honey mustard, blue cheese dressing, sliced olives, chopped garlic, lemon juice, cocktail sauce, and vanilla frosting. b.) Open food items were found in the walk-in cooler and were not labeled, dated or outdated. The food items included the following: - Four open bags of cheese - not dated or labeled - One clear package of sliced pepperoni - not labeled or dated - One package of 5 slices of raw bacon- not labeled or dated - One gallon containers of honey mustard, blue cheese dressing, and sliced olives all dated 11/19/13 - One gallon container of blue cheese dressing dated "1/20" - A 16 oz container of vanilla frosting- not labeled or dated - A bag of lettuce, ½ full- not labeled or dated - A pie pan of Quiche- dated 6/27/15	F 371	have the potential to be affected by this practice: -In-servicing of all dietary staff regarding complete daily documentation of temperature logs. -In-servicing of all dietary staff regarding turning cooler off. (not to be turned off) The following systemic changes have been implemented to ensure compliance: -All temperature logs will be copied and handed in to the facility Quality Assurance meeting for monthly review -The food service director will be responsible for implementation. monitoring and evaluation of this system 3)The entire kitchen was properly cleaned. The dietary delivery door was closed. The following corrective action was implemented to identify other areas that may be affected by this practice: -All kitchenettes and other areas were checked to ensure cleanliness, no insects. -Any open delivery doors were closed\ The following systemic changes have been implemented to ensure continued compliance: -Sign placed on delivery door to remain closed -In-servicing of all dietary staff -The food Service Director will be responsible for the implementation, monitoring of the practice. 4)The two male dietary staff members were counseled and provided the proper beard cover. -All dietary staff were in-serviced on proper hair cover The Food Service Director will be responsible for the monitoring, evaluation	

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F 371	Continued From page 2 - Two containers of hard boiled eggs- not labeled or dated - One clear plastic bag of ~20 slices of cooked bacon dated "7/6" - 1/ 16 oz bag of whipped topping- not labeled or dated - One box of donuts- not labeled or dated c.) The following food items were found in the refrigerator by the Cook's area: - One (1) quart container of sour cream and cottage cheese- not dated - Three red plastic serving bowls of unidentified food - not labeled or dated - One container of shredded cheese - not labeled or dated - Two containers of chopped garlic with mold spots - One employee lunch container and two bottles of half drank citrus green tea. An interview with the Food Service Director at the time of the observation revealed "This lunch container and drinks are an employee's and should not be in here." - The thermometer in the refrigerator had mold on the back of it. - 20-30 jars/containers of food had water condensation on the outside of them. 2. a.) Observation of the Kitchen on 7/30/15 revealed the temperature on the thermometer on the walk-in cooler door read 50 degrees. Observation of the thermometer in the walk-in cooler revealed the temperature was 50 degrees. Additional observation of the temperature in the cooler from 8:20 AM to 9:15 AM revealed the temperature did not rise above 50 degrees. Observation at 8:45 AM revealed the	F 371	of the compliance 5)The steam table pans were immediately rewashed and properly placed to dry -The plastic bin and 7-8 utensils were rewashed and properly dried -The cell phone was removed and cell phone policy reinforced -Water on the floor was mopped up and cleaned -Vents above the stove were cleaned The following corrective action has been implemented to identify any other areas in the facility that may be affected by this practice. Inspection of unit kitchenettes by dietary supervisor and Administrator. The following systemic changes have been implemented to ensure compliance: -In-servicing of all dietary staff on proper washing and drying of all equipment and utensils. Prompt cleaning of work areas -Reinforcement of no cell phones policy. -Utilizing daily audit to ensure proper cleanliness of all kitchen areas. The Food Service Director will be responsible for the monitoring, implementation and evaluation of this plan and report the results in the monthly Quality Assurance meeting 6)Temperatures of all food items were obtained after identification of missing temperatures recordings. The following corrective actions were implemented to identify other areas that have potential to be affected by this practice: -All temperature logs were reviewed in main kitchen as well as kitchenettes.	

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F 371	Continued From page 3 temperature of a 4 oz (ounce) carton of 2% (percent) milk, located in the walk-in cooler, was 42.1 degrees. At 11:05 AM, temperature taken of food items in the walk-in cooler revealed the following: - A 4 oz container of yogurt was 48 degrees - A 4 oz container of 2% milk was 47.5 degrees - A tray of of turkey croquettes was uncovered and unlabled. One of the croquettes was 49 degrees - Hard boiled eggs were 42.8 degrees - A container of minestrone soup dated 7/29/15 was 46.8 degrees Further observation of the Kitchen revealed the walk-in freezer had ice build-up on the cooling/ fan unit. The outside packaging of all of the boxed food items located in the freezer had a re-freezing build-up of ice on them. Observation on 7/30/15 at approximately 12:00 PM revealed the following food items from the walk-in cooler were voluntarily thrown away by the facility: two sheet cakes, one sheet of lemon bars, one box of tomatoes, bacon, pudding, pudding thick juice, quiche, banana pudding, tomato and onion marinade, meatballs and sauce, onions, oranges, lemons, cocktail sauce, strawberry topping, blue cheese dressing, lemon juice, olives, honey mustard dressing, cottage cheese, and donuts. Interview with the Regional Food Manager on 7/30/15 at approximately 9:20 AM revealed he did not know that the walk-in cooler had mold in there. The Regional Food Manager stated "I had the walk-in cooler doors open the other day for a delivery and that is probably when the mold grew. The walk-in cooler is cleaned once a	F 371	The following systemic changes have been implemented to ensure ongoing compliance: -All dietary staff members were in-serviced as to the checking and recording food temperatures for each meal of each day. -Cooks will be responsible for checking temperatures of each meal. -All temperature logs will be kept and labeled in the dietary office. -All temperature logs will be turned into the monthly Quality Assurance meeting for team review. The Food Service Director will be responsible for the monitoring, implementation and evaluation of this plan. 7)All food found in the refrigerator and cabinets located in the Autumn View Kitchenette was disposed of. The refrigerator and area was clean. The following corrective action was implemented to identify other areas in the facility that may be affected by this practice: -All refrigerators within the facility were checked and cleaned. All unlabeled or inappropriate items disposed of The following systemic changes have been implemented to ensure ongoing compliance: -Weekly audit tool developed for all refrigerators within the facility. Results of audits will be reviewed in the monthly Quality Assurance meeting -In-servicing of all staff on appropriate storage of employee food items. -The Food Service Director will be responsible for the implementation, evaluation and monitoring of this plan	

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F 371	Continued From page 4 week, but apparently when they clean they do not look up and that is why they didn't see the mold." The Regional Food Manager also stated "When we have a delivery, I turn the freezer unit off when I am putting the food away because it gets too cold in there for me to work." During an interview on 7/30/15 at approximately 9:30 AM, the Administrator stated "It looks like mold to me. I cannot deny it. For mold to grow like this, it takes a period of time to grow. I really did not know the mold was in here. I am having them take all the food out of the walk-in cooler, discard the open food, and once it is all out have them clean and disinfect the refrigerator." Interview with the Dietary Clerk on 7/30/15 at approximately 9:35 AM revealed "All the food in the walk-in cooler is served to the residents. This is where we store the cold foods for them. I will be throwing a lot of this food out." Interview with the Cook on 7/30/15 at approximately 9:40 AM revealed "The food that comes out of both the walk-in cooler and the refrigerator near the cook's area is served to the residents. That is where I get the food from." b.) Review of the Temperature Log for the walk-in cooler dated May 2015 revealed the log did not identify that the log was for the walk-in cooler. It was unclear which sheet was for which refrigerator. Review of the Temperature Log for the walk-in cooler dated June 2015 revealed the log was incomplete and did not document temperatures for 6/7/15, 6/12/15, 6/19/15, 6/26/15, 6/28/14, 6/29/15, and 6/30/15. Review of the Temperature Logs for the walk-in	F 371	8)The ice machine located in the Autumn View kitchenette was properly cleaned The following corrective actions have been implemented to identify other areas within the facility which may be affected by this practice: -All ice machines were assessed by the Maintenance Director and Food Service Director The following Systemic changes have been implemented to ensure ongoing compliance: -Monthly cleaning schedule has been developed to ensure cleanliness and prevent build up on ice machines. The Food Service Director will be responsible for implementation, monitoring and evaluation of this plan. 9)The refrigerator and kitchenette area of the Villages was immediately cleaned. All unlabeled food items were disposed of. The following corrective actions have been implemented to identify other areas that have potential to be affected by this practice: - All kitchenettes within the facility were audited by food service director The following systemic changes have been implemented to ensure ongoing compliance: -Weekly audit of kitchenettes in facility, results reviewed in the monthly quality assurance committee meeting. -In-servicing of all staff of storing employee food in only authorized locations. The Food Service Director will be responsible for implementation, evaluation and monitoring of this plan.	

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F 371	Continued From page 5 freezer dated May 2015 through July 2015 revealed the temperature log was incomplete and there were no temperatures recorded for 5/19/15, 5/23/15, 5/24/15, 6/15/15, 6/19/15, 6/23/15, 6/28/15, 6/30/15, 7/17/15, 7/18/15, and 7/29/15. 3. Observation of the Main Kitchen on 7/30/15 from 12:30 PM to 3:00 PM revealed there were numerous flies throughout the kitchen, including the tray line and food preparation areas. Observation of the Kitchen on 7/30/15 from approximately 12:45 PM to 1:00 PM revealed there were two uncovered dishes of food (one pureed and one beef over rice) sitting on the work bench across from the Cook's area. Interview with dietary staff at the time of the observation revealed the two dishes of food will be covered and put in the cooler in case a resident needs another tray. Interview with dietary staff on 7/3015 at approximately 2:00 PM revealed the flies come in through the Kitchen delivery door when staff go out to smoke. 4. Observation in the Main Kitchen on 7/30/15 at 12:30 PM revealed that two male dietary staff with beards were working on the tray line and in the food preparation areas and did not have beard covers on. 5. Observation of the Main Kitchen on 7/30/15 from approximately 12:50 PM to 1:30 PM revealed the following: - Four 1.1 quart size steam table pans were on a rack in the Cook's area for future use and the pans had dried food on the bottom of the pans.	F 371		

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F 371	Continued From page 6 Two larger steam table pans were observed on the same rack, stacked on one another and the pans were wet inside. Interview with a dietary worker at 12:50 PM revealed there is a drying rack near the pots and pans sink and pans are supposed to dry there so that they are not stored wet. - One plastic bin on the rack had debris in the bottom of the bin. There were 7 to 8 clean scoops for food service stored in the soiled bin. - A cell phone was plugged in and placed on top of potholder mitts on top of the large food mixer. - The floor under the workbench, across from the steamer, had a large amount of standing water that had run from the dish room. The dish room was approximately 6 feet away. An electric plug was observed on the floor in the standing water. - The floor under the workbench across from the Cooks' area had an accumulation of crumbs and debris. - The vents above the stoves were covered with film. Interview with dietary staff on 7/30/15 at 1:00 PM revealed the vents above the stoves had not been cleaned in months. The dietary staff stated that an outside vendor usually comes in and cleans them. 6. Review of a Food Temperature Logs, used to record food temperatures on the tray line, dated April 2015 to July 2015 revealed the following: - April 2015 - There were incomplete temperature logs on 4/9/15, 4/10/15, 4/13/15, 4/14/15, 4/25/15, 4/26/15, 4/27/15, 4/28/15 and 4/29/15. There were no temperature logs for 4/1/15, 4/2/15, 4/3/15, 4/4/15, 4/5/15, 4/6/15, 4/7/15, 4/11/15, 4/15/15, 4/16/15, 4/17/15, 4/19/15, 4/21/15, 4/23/15 and 4/30/15.	F 371		

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F 371	Continued From page 7 - May 2015 - There were incomplete logs on 5/1/15, 5/2/15, 5/4/15, 5/11/15, 5/15/15, 5/18/15, 5/20/15. There were no temperature logs for 5/3/15, 5/5/15, 5/6/15, 5/7/15, 5/8/15, 5/9/15, 5/10/15, 5/12/15, 5/13/15, 5/14/15, 5/16/15, 5/17/15, 5/19/15, 5/21/15, 5/22/15, 5/23/15, 5/24/15, 5/25/15, 5/26/15, 5/28/15, 5/29/15, 5/30/15, and 5/31/15. - June 2012 There were two sheets with recorded food temperatures for 6/8/15 and 6/19/15. There were no other logs were available. - July 2012 . - The Food Temperature Log dated 7/29/15 showed that lunch food temperatures were not taken for that day. Interview with the Cook on 7/29/15 at 1:00 PM revealed he did not have time to record the temperatures that day for lunch. There were no other logs for July 2015 except for 7/29/15 Interview with the Dietary Clerk on 7/30/15 at approximately 2:15 PM revealed it is the responsibility of the Cooks to take temperatures of the food in the kitchen and put the recorded temperature logs on the clipboard in the kitchen. Observation of the designated clipboard at the time of the interview revealed there were no other food temperature logs there. Interview with the Regional Manager of Dietary Services at this time reveled the Regional Manager thought the Cooks took temperatures but he did not know where the temperature logs were. 7. Observation of the Autumn View nourishment kitchenette on 7/30/15 at 1:00 PM revealed the refrigerator and freezer were both dirty. Several areas of food spillage were noted on the bottom of the refrigerator and in the drawers. There	F 371		

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F 371	Continued From page 8 was a chocolate syrup like substance spilled all over the bottom of the freezer. The following employee foods were found in both the refrigerator and freezer: a plastic bag of Swiss cheese and pepperoni slices labeled with an employee's name on it; one plastic bag with a box of a frozen glazed chicken dinner, a poppy seed bagel, and a breakfast sandwich and cheese stick; four containers of cream cheese, a container of chip dip and one container of mayonnaise; and a Styrofoam container of food with an employee's name on it. Observation of the cupboards in the kitchenette revealed approximately seven open bags of chips/ snack mixes and one half plastic bag of a peach loaf. Interview with the Registered Nurse (RN) Charge Nurse at this time revealed "All this food you found are the employee's food. It should not be in here and I will throw them all away." 8. Observation of the ice machine located in the Autumn View kitchenette on 7/30/15 at 1:30 PM revealed there was a lime build up on the ice dispenser spout and on the drain. Further observation revealed the kitchenette counters were soiled with grime and visible dirt that was removable with paper towel. Interview with a food service worker at that time revealed there was no cleaning schedule for the kitchenette or the ice machine. 9. Observation of the Village Unit kitchenette on 7/30/15 at 1:45 PM revealed the refrigerator was dirty and there were food stains on the floor. A refrigerator under the serving area was	F 371		

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F 371	Continued From page 9 labeled "Resident's refrigerator" and smelled of rotten food. The refrigerator had multiple areas of food stains on the bottom and contained the following food items that were either not labeled and/or not dated: - A fruit pie wrapped in foil, not labeled and dated - Styro-foam container of pizza, dated "6/19" - Two jars of homemade jelly, dated "6/19" - A 4 oz container of yogurt, dated 9/12/14 - Approximately 3 cups of fruit, not dated or labeled - 1/2 cup of ice cream in a Styrofoam cup, not dated or labeled - 1 jar of apricot preserves, no date or label - 2 containers of food with no label or date - bag of pizza dated 6/15 Interview with a dietary aid on 7/30/15 at 1:45 PM revealed "This is the resident's refrigerator. I do not know who takes care of it. The kitchen has nothing to do with it. I believe nursing may be responsible for it. I will go through it and throw everything out that is not labeled properly.". Interview with RN Charge Nurse on 7/30/15 at 1:50 PM revealed "That refrigerator is for resident use only. All the food in there is residents' food, usually brought in by the families. I do not know who takes care of that refrigerator. The nurses do not clean it or take temperature on that refrigerator." Interview with the Regional Food Service Manager on 7/30/15 at 2:00 PM revealed "The resident's refrigerator is for residents' food that is brought in for them. Dietary does not take care of that refrigerator, as it is not our refrigerator. Nursing is to be taking care of it and I do not	F 371		

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F 371	Continued From page 10 know if they are taking temperatures on it." 415.14(h) 14-1: 14-1.40(a) 14-1.72(c) 14-1.90 14-1.160 14-1.171 14-1.172 14-1.175	F 371		

EXHIBIT 24

acceptable
10/29/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2015
FORM APPROVED
OMB NO. 0938-0391

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(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) COMPLETE DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews conducted during an Abbreviated Survey (Complaint #NY00169951) completed on	F 157	The following corrective actions have been implemented for the deficiency cited: A) A complete chart review for resident #1 was done by Director of Nursing. Nursing staff has been in-serviced on proper and timely MD / responsible party notification. B) The 24 hour report sheets have been reviewed by the Director of Nursing and Assistant Administrator for the past 30 day period to identify any other residents that may have been affected by this practice. C) The policy dictating the process by which, and when, a physician is notified because of a "change in condition" has been reviewed. All nursing staff will be in-serviced regarding proper notification of resident's MD and resident's legal representative/family. D) All Nursing staff have been in-serviced on prompt MD and legal representative/family notification, as well as reporting via 24 hour nursing report sheet any and all residents with a "change of condition." The following systemic changes have been implemented to ensure continued compliance with the regulation: A)The Director of Nursing or RN designee will assess residents identified on 24 hour report sheet and ensure proper compliance with notification practice. The results of this audit will be reported in the facility Quality Assurance Meeting for 6 months to identify facility compliance with the regulation. B) The Director of Nursing or designee will conduct chart audits (15 random resident charts per month)to assess any changes in condition including increased temperature to ensure nursing staff compliance. the results of chart audits will be reported in the facility Quality Assurance Meeting for 6	10/27/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Electronically Signed — (X6) DATE: 10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	10/13/2015

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

(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) COMPLETE DATE
F 157	Continued From page 1 10/13/15, the facility had a delay in notifying the Physician and the resident's legal representative of a significant change in condition. Specifically, One (Resident #1) of three residents reviewed for notification had a delay in Physician and responsible representative notifications for a change in level of awareness, a low grade temperature (temp) and difficulty swallowing. The finding is: 1. Resident #1 has diagnoses that include dementia, and hypertension (HTN-elevated blood pressure). Review of the Care Plan dated 8/26/15 revealed the resident has severe cognitive impairment and is dependent on staff for meeting needs. Review of August 2015 Progress Notes revealed the following: - 8/13 Temp 99.3° (degrees) Farinheight (F) at 9:00 PM. Tylenol given and recheck of temp shows a decrease to 98.8° F. - 8/14 Temp at 11:00 PM 100° F. 100.2° F at 12:30 AM - 8/15 Temp 100.2° F at 11:00 PM. 99.7° F at 2:00 AM - 8/20 Temp 99.2° F Resident is not like himself. - 8/22 at 8:00 AM Registered Nurse (RN) Evaluation due to reported change in condition. Two plus edema (a collection of fluid under the skin) noted at the left foot & ankle with skin cool to touch. - 8/22 at 1:30 PM Resident in bed for the shift. Face is flushed. Resident noted to have difficulty swallowing his food and coughing with liquids. Resident not himself. Temp 99.5° F at 5:00 PM. - 8/23 at 9:27 AM Resident flaccid and not himself, difficulty with swallowing. Foul odor noted to the left hip when dressing changed this	F 157	months to further identify facility compliance with the regulation. The Director of Nursing will be responsible for implementation, monitoring, and evaluation of this plan.	

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THE VILLAGES OF ORLEANS HEALTH AND REHAB CTR	14012 ROUTE 31 ALBION, NY 14411

(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) COMPLETE DATE
F 157	Continued From page 2 morning. Congested cough is noted. Family notified and wish for the resident to be sent to the hospital for an evaluation. Physician #1 was notified and resident to be sent to the hospital for an evaluation. Ambulance transported the resident to the hospital at 9:30 AM. Review of all of the entire Medical Record and the Unit 24 Hour Report sheets dated 8/19/15 through 8/22/15 revealed a delay in notifying the Physician and the resident's responsible party regarding the low grade temp, change in resident status, vital signs and difficulty swallowing. During an interview with the #2 Physician on 9/30/15 at approximately 1:45 PM, revealed Physician #2 expects to be notified by the staff when the resident runs a low grade temp. During an interview with Physician #1 on 10/1/15 at approximately 12:00 PM, revealed Physician #1 expects to be notified when there is a change in vital signs, physical status and difficulty swallowing. Review of a facility policy and procedure dated 9/2012 entitled Care Path revealed: a fever is to be evaluated if it is greater than 99.° F twice. If nursing assessment shows there is a change in mental status and functional status the Physician is to be called. Any symptom or sign that is a marked change in relation to usual for the resident is to be reported to the Physician.	F 157		
F 309 SS=D	415.3(e)(2)(ii)(b) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to	F 309	The following corrective actions have been implemented for deficiency cited: A) The Director of Nursing reviewed charts of all current resident identified with pressure ulcers to ensure all MD orders	10/29/2015

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F 309	Continued From page 3 attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated Survey (Complaint #NY00169951) completed on 10/13/15, the facility did not ensure that each resident received the necessary care and services to maintain or attain the highest practicable physical, mental and psychosocial well- being, in accordance with the comprehensive assessment and plan of care. One (Resident #1) of three residents reviewed for quality of care had issues involving a lack of follow through of a Physician's order for a wound consultation; lack of a thorough Registered Professional Nurse (RN) assessment for a resident with a change in level of awareness, a low grade temperature (temp) and difficulty swallowing. The finding is: 1a. Resident #1 has diagnoses that include dementia, and hypertension (HTN-elevated blood pressure). Review of the Care Plan dated 8/26/15 revealed the resident has severe cognitive impairment and is dependent on staff for meeting needs. Review of the Skin/ Wound Note dated 6/24/15 revealed the resident has an abrasion (a surface scraping of the skin) on the left posterior (back of) thigh. The area is open deeper with yellow slough (soft, moist, dead tissue may be white, yellow, tan or green) and a foul odor. Wound does not show improvement. Skin team	F 309	including consultant referrals were properly completed and scheduled B) Resident #1 medical record was reviewed by the Director of Nursing and no other issues were identified. C) All nursing staff were in-serviced immediately, in accordance with the policy, indicating when it is appropriate to complete a full assessment on a Resident when change in condition is identified, including but not limited to; increase in temperatures, as well as progression of wounds. The following corrective actions have been implemented to identify other areas within the facility that have potential to be affected by this practice: A) Based on 24 hour report sheet, any resident's with a "change in condition" will have their medical records reviewed, for a period of three months, by the Director of Nursing/designee. B) All nursing staff have been in-serviced as to the policy and procedure of completing SBAR,(Situation, background, assessment, request)communication tool which contains all pertinent information, MD notification requires, regarding resident's "change in condition." C) All nursing staff have been in-serviced regarding the expectation of reviewing physicians orders, and ensuring recommended consultations are scheduled via medical records department or contacting consulting MD for in-house consultaion. The following changes have been implemented to ensure continued compliance occurs:	

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F 309	Continued From page 4 suggests wound treatment change to Santyl gel (a sterile ointment used to remove dead skin tissue) covered with a dressing and tape. Review of a Physician's Note dated 7/2/15 revealed the resident had developed a left posterior thigh wound that has worsened over the last week. The area has had a culture obtained (a test to verify if infection present) and the area is a skin ulceration. Review of a wound culture result dated 7/2/15 revealed the resident's wound is infected. Review of a Physician's Order dated 7/6/15 revealed orders to begin an antibiotic, have blood work drawn and for a wound consultation with Physician #2 on 7/8/15. Review of the Progress Notes and 24 Hour Report sheets dated 7/6/15 through 7/8/15 revealed Physician #2 was not contacted to see the resident per the Physician's Order dated 7/6/15. Review of the Skin/ Wound Note dated 8/12/15 revealed the abrasion has progressed to a Stage 3. The area is reddened with gray slough in the wound. Review of the Care Plan dated 8/26/15 revealed the resident is at risk of pressure ulcer development and has actual alteration in skin integrity at the left hip. Approaches include to assess, monitor and record wound healing. To measure length, width and depth when possible. Assess wound bed and healing progress. Monitor for changes in wound size and stage. Report improvements and declines to the MD (Medical Doctor).	F 309	A) A daily audit completed by the Unit Charge nurse will be conducted on each Resident identified with a change in condition as reported on the 24 hour report to ensure a RN assessment has been completed. B) The Director of Nursing will review every resident identified with wound or pressure ulcer during the weekly skin rounds to ensure any referrals for consultant is scheduled and completed. The results of this audit will be reported in the facilities Quality Assurance Meeting for 6 months to identify compliance with the regulation The Director of Nursing will be responsible for implementation, evaluation and implementation of this plan.	

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F 309	Continued From page 5 Interview with the RN Assistant Director of Nursing (ADON) on 9/21/15 at approximately 3:00 PM revealed the ADON leads the Skin Team was not aware that there was a Physician's Order for a Wound Consultation. During an interview with the RN Unit Manager (UM) on 9/30/15 at approximately 1:45 PM, the RN UM stated that on 7/8/15 she did not notify Physician #2 regarding the order for a Wound Consultation. During an interview with Physician #2 on 9/30/15 at approximately 1:45 PM, Physician #2 stated he was not notified there was an order for him to evaluate Resident #1 on 7/8/15. Physician #2 stated he would have gladly seen the resident if he was aware there was an order to do so. b. Review of August 2015 Progress Notes revealed the following: - 8/13 Temp 99.3° (degrees) Farinheight (F) at 9:00 PM. Tylenol given and recheck of temp shows a decrease to 98.8° F. - 8/14 Temp at 11:00 PM 100° F. 100.2° F at 12:30 AM - 8/15 Temp 100.2° F at 11:00 PM. 99.7° F at 2:00 AM - 8/20 Temp 99.2° F Resident is not like himself. - 8/22 at 8:00 AM RN Evaluation due to reported change in condition. Two plus edema (a collection of fluid under the skin) noted at the left foot and ankle with skin cool to touch. - 8/22 at 1:30 PM Resident in bed for the shift. Face is flushed. Resident noted to have difficulty swallowing his food and coughing with liquids. Resident not himself. Temp 99.5° F at 5:00 PM. - 8/23 at 9:27 AM Resident flaccid and not himself, difficulty with swallowing. Foul odor noted to the left hip when dressing changed this	F 309		

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F 309	Continued From page 6 morning. Congested cough is noted. Physician #1 was notified and resident to be sent to the hospital for an evaluation. Ambulance transported the resident to the hospital at 9:30 AM. During an interview with the RN UM on 9/30/15 at approximately 1:45 PM, the RN UM stated she did not perform an assessment of the resident form 8/11/15 through 8/22/15. The RN UM stated that when there is a change such as a repeated low grade temp, such as 99.5° F to 101° F and a change in physical or mental status, an RN should do a complete assessment that includes vital signs (Blood pressure, temp, heart rate and respirations rate), listening to lung and bowel sounds and a physical assessment. Interview with a Licensed Practical Nurse (LPN #2) on 9/30/15 at approximately 3:00 PM revealed the resident had a change in physical status on 8/22/15 including not acting his usual self as shown by not striking out at staff when approached or hollering out with approach of care. He appeared to be flaccid, was noted to be having difficulty swallowing and both feet were quite swollen. The LPN asked the RN Supervisor (RN #3) to evaluate the resident. RN #3 saw the resident and told the LPN the resident had two plus edema of both feet. RN #3 did not listen to the resident's lung, heart or bowel sounds. RN #3 directed to continue to observe the resident. LPN #2 stated she gave report at the change of shift to LPN #1 regarding her concerns including: the change in the resident's behaviors and foot edema. LPN #2 requested LPN #1 to have the night RN assess the resident. LPN #2 stated she returned in the morning to work the day shift and recieved report that the staff did check on the resident quite often but that an RN did not perform an	F 309		

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F 309	Continued From page 7 assessment of the resident. LPN #2 checked on the resident and found him with wet sounding respirations, a low grade temp and generally "looking very ill." LPN #2 changed the resident's dressing at the left posterior hip and reported the wound smelled foul and was much larger than the last time she saw it about two weeks prior. LPN #2 stated there was no RN present in the building at that time. LPN #2 called the Physician and 911 and the resident transported to the hospital. Interview with RN #3 on 9/30/15 at approximately 2:25 PM revealed RN #3 was asked to look at the resident as staff was concerned there were changes. RN #3 noted the resident had edema of the feet but thought that was usual for the resident. RN #3 did not recall having checked vital signs, listening to the resident's lung and bowel sounds. In addition, RN #3 did not document his findings on the 24 Hour Report "as the floor nurses usually do that." Interview with the ADON on 9/30/15 at approximately 3:00 PM revealed that if there is a change in status of a resident, the floor nurse is to notify the RN and it is expected the RN would assess the resident; to include listening to the lung and bowel sounds, checking vital signs, evaluating intake of food and liquids.	F 309		
F 314 SS=D	415.12 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314	The following corrective actions have been implemented for deficiency cited: A) complete chart review for resident # 1 was done by the Director of Nursing. Nursing staff has been in-serviced on proper and timely MD / responsible party notification for any change in condition. B)The Director of Nursing and facility nurse	10/27/2015

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F 314	Continued From page 8 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews conducted during an Abbreviated Survey (Complaint #NY00169951) completed on 10/13/15, the facility did not assure that a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. One (Resident #1) of three residents reviewed for pressure sores had an issue involving the lack of proper assessment and staging of a wound. The finding is: 1. Resident #1 has diagnoses that include dementia, and hypertension (HTN-elevated blood pressure). Review of the Care Plan dated 8/26/15 revealed the resident has severe cognitive impairment and is dependent on staff for meeting needs. Review of the Skin/ Wound Note dated 6/24/15 revealed the resident has an abrasion (a surface scraping of the skin) on the left posterior thigh. The area is open deeper with yellow slough (soft, moist, dead tissue may be white, yellow, tan or green) and a foul odor. Wound does not show improvement. Skin team suggests wound treatment change to Santyl gel (a sterile ointment used to remove dead skin tissue) covered with a dressing and tape.	F 314	practitioner assessed all residents within the facility identified with a pressure ulcer/wound to ensure proper wound staging. C) The Director of Nursing then reviewed all resident orders, assessment and related documentation of all residents physically assessed by skin team members including NP. D) The assistant director of nursing (RN)attended educational series regarding proper wound staging The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A) All nursing staff and members of skin team have been in-serviced on proper staging of wounds based on Assistant Director of Nursing educational series. B) For wounds stage 2 or greater, MD will be asked to assess wound every 2 weeks when skin team deems that wound is not adequately improving. C) All skin team residents' medical records were reviewed by the skin team, to ensure all wounds were properly staged. All wounds were found to be staged properly. The following systemic changes have been implemented to ensure continued compliance with this regulation: A)Unit RN Charge will be present on skin rounds so they are aware of staging, progression or decline in wound healing and may contact MD accordingly. B)Weekly review of pressure ulcer documentation, staging, consultant referrals, by Assistant Director of Nursing, will be part of the skin team report	

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F 314	Continued From page 9 Review of a Physician's Note dated 7/2/15 revealed the resident had developed a left posterior thigh (back of) wound that has worsened over the last week. The area has had a culture obtained (a test to verify if infection present) and the area is a skin ulceration. Review of the Skin/ Wound Note dated 7/8/15 revealed the abrasion on the posterior thigh has gray slough in the wound bed with redness surrounding the area. The resident was started on an antibiotic and Santyl treatment continues. Review of the Nurse Practitioner (NP) Note dated 7/17/15 revealed the NP observed the skin area on the left hip noting that the site was originally an abrasion but now has 100% (percent) gray slough and is red and warm around the wound. Resident's area is non-improved so will begin an antibiotic and monitor. Review of the Skin/ Wound Note of 7/22/15 revealed the abrasion on the resident's thigh has a gray slough wound bed with moderate drainage and reddened skin surrounding the wound bed. Wound is deeper and a wound consult will be recommended by the skin team. Review of the Physician's Note dated 7/26/15 revealed the resident has an ulceration of the posterior thigh which has not improved. A wound consultation was requested. Review of the Physician's wound care instructions dated 7/31/15 revealed the resident's wound was evaluated and a wound vac (a closed system wound therapy) was suggested. Review of the Skin/ Wound Note dated 8/5/15 revealed the skin team discussed the wound vac	F 314	reviewed in the monthly quality assurance meeting B)Skin Team reports will be monitored in the Quality Assurance Meetings on an continual basis. The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 314	Continued From page 10 and felt that due to dementia, the resident would pull the dressing off and the treatment is not appropriate for this resident. Review of a Physician's Order dated 8/11/15 revealed an order to discontinue the wound vac recommendation. Review of the Skin/ Wound Note dated 8/12/15 revealed the abrasion has progressed to a Stage 3. The area is reddened with gray slough in the wound. Review of the Care Plan dated 8/26/15 revealed the resident is at risk pressure ulcer development and has actual alteration in skin integrity at the left hip. Approaches include to assess, monitor and record wound healing. To measure length, width and depth when possible. Assess wound bed and healing progress. Monitor for changes in wound size and stage. Report improvements and declines to the MD (Medical Doctor). Interview with the Registered Nurse (RN) Assistant Director of Nursing (ADON) on 9/21/15 at approximately 3:00 PM revealed the ADON leads the Skin Team in rounds and resident assessment. The ADON stated the wound had deteriorated for multiple weeks showing it to be deeper and filled with slough. The ADON stated "I did not label it as a staged pressure wound. I was under the impression that wounds were not to be changed from the original labeling. This wound that had began as an abrasion had extended to involve tissue beyond the surface. I changed the wound to a Stage 3 when I found out the wound had not been correctly assessed as a staged pressure ulcer." 415.12(c)(1)	F 314		

EXHIBIT 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	04/25/2016

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

(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) COMPLETE DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during the Standard survey completed on 4/25/16, the facility did not promote care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Two (Autumn North, Assist Dining Rooms) of five dining rooms observed for dignity during meals had issues involving staff standing while assisting a resident to eat, staff sitting on resident equipment (seated rolling walker) while assisting a resident to eat, and lack of timely assistance during meals. Residents #12, 114, and 128 were involved. The findings are: 1. Resident #128 has diagnoses including hypertension, coronary artery disease, and dementia. Review of the Minimum Data Set (MDS - a resident assessment tool) dated 2/10/16 revealed the resident has severely impaired cognition and requires extensive assistance with eating. During a meal observation in the Autumn North Dining Room on 4/22/16 at 12:04 PM, a Certified Nurse Aide (CNA #6) was assisting Resident #128, who was seated in a Geri chair (a reclining chair with wheels), with his meal while	F 241	The following corrective action has been implemented for the deficiency cited: 1)CNA #6 was reeducated on using a appropriate chair as opposed to inappropriately sitting on a residents walker 2)facility management inventoried the stools and available chairs in each resident dining area and determined that sufficient seating equipment is available for staff 3)LPN #4 was reeducated on proper technique to be utilized when feeding residents 4)All facility nursing staff were in serviced on appropriate technique and expectations to maintain resident dignity when assisting with meal intake 5)All facility nursing staff were in serviced on expectations to begin assisting residents with feeding within 5 minutes of trays being distributed 6)Resident #114 has been reevaluated by interdisciplinary team members (Nursing, Speech therapist, Registered Dietician)to determine if care plan adjustment regarding meals is warranted based on CNA #8 comment "nags" the resident "will not eat at all" 7)Additionally, Resident's #12 & 128 have also been reviewed by Director of Nursing, and Registered Dietician to assess meal consumption, participation and satisfaction The following actions have been completed to identify other residents within the facility that have potential to be affected by this deficiency: 1)Audit by facility Administrator, Director of Nursing, Director of Social Work in every dinning area for all three meals was conducted	06/17/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	05/24/2016

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	335212	A. BUILDING _____ B. WING _____	04/25/2016

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F 241	Continued From page 1 sitting on a seated rolling walker, belonging to Resident #68. The CNA assisted Resident #128, while sitting on the rolling walker, until approximately 12:20 PM. During an interview on 4/22/16 at 12:43 PM, CNA #6 stated that she used the walker because there weren't enough stools to sit on. The CNA stated that they "need more stools". During an interview on 4/22/16 at 1:33 PM, the Director of Nursing (DON) stated that staff should be seated when assisting residents with their meals. The DON stated that the CNA "should have pulled up a chair and should not have used resident equipment like that". 2. Resident #12 has diagnoses including dementia and depression. Review of the MDS dated 4/13/16 revealed the resident has severely impaired cognition and requires extensive assistance with eating. During a meal observation in the Autumn North Unit Dining Room on 4/22/16 at 12:11 PM, a Licensed Practical Nurse (LPN #4) was approached Resident #12, who was seated in a chair at the dining table, and while standing gave the resident a sip of Boost Plus (liquid nutritional supplement). The LPN was observed to then give the resident a sip of cranberry juice and three bites of her pureed entrée while standing. The LPN then crouched down next to the resident and assisted the resident with the rest of her lunch until approximately 12:25 PM. During an interview on 4/22/16 at 12:41 PM, LPN #4 stated she knows she's supposed to sit and be at the resident's eye level when feeding but she couldn't fit a chair between the resident's chair and the visitor's chair, "that's why I	F 241	The following systemic changes have been implemented to ensure continued compliance with the regulation: 1)Adjustments were made to time frame that staff were taking scheduled breaks/lunch to ensure all staff are on the nursing units during resident meal times. 2)Facility verified that currently there is adequate seating available for staff to properly feed while seated. 3)A daily audit will be conducted by Administration or designee to specifically identify that all staff assisting with resident feeding are in seating position and maintaining dignity for the resident 4)A daily audit will be conducted by Administration or designee to specifically identify time frame from dining tray being placed on table to actual time resident begin being fed 5) Both the above audits (#3,#4) will be conducted on random days including weekends and for all three daily meals 6)The results of the audits will be presented and reviewed in the facility monthly Quality Assurance committee meeting until determined in compliance The Director of Nursing will be responsible for implementation and evaluation of this corrective action	

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F 241	Continued From page 2 crouched down next to the resident to get to her eye level". 3. Resident #114 has diagnoses of dementia, anxiety, blindness, and glaucoma. Review of the MDS dated 3/16/16 revealed that the resident has severe cognitive impairment and needs the extensive assistance of one person for eating. Review of the current Comprehensive Care Plan revealed an intervention for one staff to provide extensive assistance for eating. Observation of the lunch meal in the Assist Dining Room on 4/21/16 at approximately 12:14 PM revealed that the resident's lunch tray was placed in front of the resident by staff. The tray contained several bowls and cups with plastic covers on them. The resident was observed to be sitting in a fetal position on her left side in a Geri chair. The tray remained in front of the resident for approximately 23 minutes and at approximately 12:37 PM , staff sat down and began feeding the resident. Observation of the dinner meal in the Assist Dining Room on 4/21/16 at approximately 5:02 PM revealed the resident's meal tray was placed in front of the resident by staff while she was sitting upright in her Geri chair . The tray contained several bowls and cups with plastic covers on them. The tray remained in front of the resident for 22 minutes and at approximately 5:24 PM, CNA #8 was observed to approach the resident, say something to the resident, and then walked away. Interview with CNA #8 on 4/21/16 at approximately 5:27 PM revealed that she checks with the resident every "5 to 10" minutes to see	F 241		

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F 241	Continued From page 3 if the resident wants to eat. The CNA stated that if she "nags" the resident, she "will not eat at all". Interview with a Registered Nurse (RN #2) on 4/22/16 at approximately 10:52 AM revealed that she would have to find out why it takes so long for the resident to be assisted. The RN stated this was a "dignity issue".	F 241		
F 258 SS=D	415.5(a) 483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview during the Standard survey completed 4/25/16, the facility did not ensure there were comfortable sound levels during dining. One (Assist Dining Room) of five dining rooms observed for comfortable sound levels had an issue with loud noise levels during meals. Residents #29, 44, 78, and 114 were involved. The findings are: 1. Interview with a family member of Resident #114 on 4/20/16 at approximately 8:40 AM revealed that Resident #114 "can't handle the noise in the dining room" and becomes "agitated" during meals. The family member stated that she has repeatedly asked the facility to not place the resident in the dining room because of the noise. Observation of the Assist Dining Room on 4/21/16 from approximately 12:10 PM to 12:35	F 258	The following corrective actions have been implemented for the deficiency cited: A)Resident #114 has been relocated to the common area for her meals where it is quiet and should she yell out, will not be disruptive to others. B)Resident #114 Plan of Care has been updated for meals in the resident common area. C) All staff have been in-serviced on importance of low noise levels during meals. D)Resident #29, 44, 78 have been reviewed by Director of Nursing, Director of Social Work to determine appropriateness of current dinning room placement and any further concerns associated with dinning room experiences The following corrective changes have been implemented to identify other areas within the facility that have the potential to be affected by this deficiency: A)Any disruptive residents in the dining room setting will be relocated to common area/resident room. The following systemic changes have been implemented to ensure continued compliance with this regulation: A)The Director of Nursing or RN designee	06/17/2016

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F 258	Continued From page 4 PM revealed that Resident #114 was seated next to Resident #29. Resident #29 yelled out every few seconds for approximately 25 minutes. Resident #114 was observed to be in the fetal position in her Geri chair with her food tray in front of her and she was not eating. Observation of the Assist Dining Room on 4/21/16, from approximately 4:42 PM to 5:26 PM, revealed that Resident #114 was seated at another table approximately 15 feet away from Resident #29. Resident #29 yelled out every few seconds for approximately 30 minutes. Another resident, Resident #78, yelled at staff to "shut her up! I can't hear anything!". Approximately five minutes later, Resident #78 yelled "shut up!" to Resident #29. Resident #78 muttered for the staff to keep Resident #29 "quiet". Interview with the Social Worker (SW) on 4/22/16 at approximately 10:23 AM revealed that the Assist Dining Room is "very loud". Interview with a Registered Nurse (RN #2) on 4/22/16 at approximately 10:53 AM revealed that the Assist Dining Room "is very loud and a lot of people are in there talking". During an interview on 4/22/16 at approximately 1:30 PM, Resident #44, who also eats in the Assist Dining Room, stated that it bothered him because the dining room is "loud". 415.5(h)(5)	F 258	will audit & monitor meal times daily to ensure compliance with low noise levels. The results of these audits will be reported to the facility Quality Assurance meetings for 3 months or compliance determined by the Quality Assurance Committee. B)A policy reflecting disruptive behaviors in common areas, including situations of when a resident should be relocated for meals from a dining room has been instituted and all staff have been in serviced to this policy. C)Unit RN shall be responsible to direct staff to relocate residents that are disruptive during meals per new policy. The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	The following corrective actions have been implemented for the deficiency cited: A)Resident #107 Plan of care has been reviewed by The Director of Nursing and updated to include side effects of anticoagulants and documentation of side	06/17/2016

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F 279	Continued From page 5 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 2/6/15. Based on observation, interview and record review conducted during the Standard survey completed on 4/25/16, the facility did not develop a comprehensive Care Plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs. Two (Residents #71, 107) of 22 residents reviewed for Care Plan development did not have a Care Plan developed to address the use of an anticoagulant (medications used to prevent blood from clotting) medication (Resident #107) and use of a non-tipping chair and bolster cushion (Resident #71). The finding is:	F 279	effects of anticoagulants are reflected on the CNA Kardex. B)All Plan of Care for residents on anticoagulants have been audited and corrections made to include side effects of anticoagulants that are reflective on the CNA Kardex. C)Resident #71 has been assessed by therapy department for positioning D)A Plan of Care for resident #71 has been developed for new chair and positioning devices which resident has recieved The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A)Plan of care for all residents on anticoagulants will be audited on weekly basis by The Director of Nursing or RN designee for 3 months and results will be reported in the Quality assurance meetings. B)All Nurses have been in serviced on proper and timely updating care plan for side effects of medications. C)The Therapy Director has audited all residents with specialty chairs and positioning devices to ensure all devices have been Care Planned for. Audits will be conducted on all residents initially picked up by Therapy to ensure Care Planning of devices for 3 months and results reported to the Quality Assurance meetings. The following systemic changes have been implemented to ensure continued compliance with this regulation: A)The Policy on Development of Care Plans has been revised to include side effects of medications when developing	

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F 279	Continued From page 6 1. Resident #107 has diagnoses including a hip fracture, hypertension (HTN-high blood pressure), and anxiety. Review of the admission Minimum Data Set (MDS - a resident assessment tool) dated 3/31/16 revealed the resident's medications include antidepressants, antianxiety, and anticoagulants. Review of Physician's Orders dated 3/24/16 through 4/18/15 revealed multiple orders addressing the resident's Coumadin (anticoagulant medication) doses based on INR (international normalizing ratio-standardized normalized blood coagulation levels) results. Review of the Medication Administration Record (MAR) dated April 2016 revealed the resident received Coumadin in accordance with Physician's orders. Review of the Comprehensive Care Plan (CCP) dated 3/31/16 revealed there was no documentation addressing the use of the Coumadin and to monitor for signs of bleeding. Review of the certified nurse aide (CNA) Visual/Bedside Kardex Report (care guide) revealed there was no documentation addressing the use of Coumadin and to monitor for signs of bleeding. During an interview on 4/22/16 at 1:27 PM the Registered Nurse (RN) Director of Nursing (DON) stated that the facility has two weeks to get a Care Plan into place when a resident is first admitted. When informed that the resident has been in the facility since 3/24/16, the DON stated then the Coumadin should be on the Care Plan. Review of the facility policy entitled	F 279	Plan of Care. B)Audits of Plan of Care on all new admissions will be conducted by The Director of Nursing or RN designee within 72 hours of admission to ensure side effects of anticoagulants is included in Plan of Care and reflects on CNA Kardex.Results of audits will be reported in Quality Assurance meetings. C)The Director of Therapy or Designee will in-service staff yearly and when new devices are instituted, on proper positioning of residents with specialty chairs and positioning devices and keep records of this for yearly in-servicing requirements. The Director of Nursing will be responsible for overall monitoring, evaluation, and implementation of this plan.	

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F 279	Continued From page 7 "Interdisciplinary Care Plan" last revised 2/2015, revealed all classifications of medications will be individually addressed on the Care Plan and significant side effects will be transferred to the Bedside Kardex Report for all direct care givers to be aware of. 2. Resident #71 has diagnoses which include Alzheimer's disease, anxiety disorder, and diabetes mellitus. Review of the MDS dated 2/24/16 revealed the resident is severely impaired for decision making. The resident was observed on 4/19/16, 4/20/16, 4/21/16, and 4/22/16 positioned in a specific chair that angles back. The resident was observed leaning over the left side of the chair on 4/20/16 at approximately 9:15 AM and at 9:50 AM she was observed with a pillow between her left shoulder and the arm of the chair. Interview with Physical Therapist on 4/22/16 at 1:25 PM revealed the chair is an anti-tipping chair generally used for dementia residents to keep them from "falling out." Review of the CCP and the Visual/Bedside Kardex Report revealed a lack of Care Plan development for the anti-tipping chair and the use of bolsters for positioning. During an interview on 4/22/16 at 1:25 PM the Physical Therapist stated there is no Care Plan developed for the use of the chair and/ or bolster. During an interview on 4/25/16 at 10:00 AM the DON stated that "the resident has been in that chair for three years. It's the only way they can keep her from falling on her face."	F 279		

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F 279	Continued From page 8 415.11(c)(1)	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during the Standard Survey completed on 3/25/16, the facility did not ensure that the Comprehensive Care Plan (CCP) is periodically reviewed and revised to include measurable goals and interventions. Four. (Residents #12, 59, 93, 104) of 22 residents reviewed for revision of the Care Plan did not have a revised Care Plan for the increased level of assistance required to eat (Resident #12), for a change in dosage of a psychotropic medication and the need for increased assistance to eat (Resident #59), for the	F 280	The following corrective actions have been implemented for the deficiency sited: A)Resident #93 Plan of Care was updated by Assistant Director of Nursing to include treatment of UTI as of 4/12/16. B)Use of dycem on seat of wheelchair for resident #93 was added to Kardex by the Assistant Director of Nursing. c)All nursing staff have been in-serviced on Interdisciplinary Care Plan, need for plan of care to be updated when changes occur and how to include that change on the CNA Kardex. D)Resident #104 Plan of care was reviewed by Assistant Director of Nursing; Plan of Care, Kardex and Treatment records were all updated to reflect the location of resident #104 wanderguard bracelet. E)Plan of care and Kardex for resident #104 was updated by Assistant Director of Nursing to include physically aggressive behaviors towards staff. F)Resident #104 Plan of Care and Medication record were both reviewed by Director of Nursing to reflect GDR of Seroquel and the result of that GDR. G)Resident #12 Plan of Care and Kardex were updated by the Assistant Director of Nursing to reflect increased need for feeding assistance. H)Resident #59 Plan of Care was updated by Assistant Director of Nursing to reflect change of psychotropic med dose and need of increased assistance to eat. Increased need for assistance with eating was also added to Kardex. The following corrective actions have been	06/17/2016

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F 280	Continued From page 9 development of a urinary tract infection (UTI) and the use of Dycem (a non-slip, self-adhesive mat) (Resident #93) and the physical aggressiveness of a resident towards other residents and staff as well as the change in location of the resident's Wanderguard (a device to detect wandering) (Resident #104). The findings include but are not limited to: 1. Resident #93 has diagnoses that include coronary atherosclerosis (heart disease), senile dementia, and macular degeneration (loss of the central field of vision). Review of the Minimum Data Set (MDS - a resident assessment tool) dated 1/28/16 revealed the resident has moderate cognitive impairment, understands and is understood. Review of the Resident Incident/ Accident Report (A&I) dated 4/11/16 at 7:25 AM revealed the resident was found on the floor sitting in front of the wheelchair. Staff documented that the resident said she slid out of the wheelchair. Further review of the A&I revealed the changes instituted to prevent reoccurrence included "Dycem on wheelchair pad to stop sliding" and "resident tested positive for UTI and being treated with antibiotic at this time." Review of Physician's Orders dated 4/11/16 revealed an order order "Resident was on the floor this morning, has no injuries, denies pain. Dycem put in chair to stop slipping." Further review of Physician's Orders revealed the following: - 4/12/16 Macrobid (antibiotic medication) 100 milligrams (mg) po (by mouth) bid (twice daily) for seven days.	F 280	implemented to identify other areas that have the potential to be affected by this same practice: A)An audit of all residents care plan, kardex, and closet care plans was conducted by RN nurse managers to ensure current accuracy B)All Nurses have been educated and in serviced on how to update a care plan when any changes take place with a resident; this included making sure the change is reflected on the CNA Kardex. C) Director of Nursing or designee will audit all 24 hour report sheet to ensure changes in residents meds, assistive devices, UTI's and change in eating assistance needed, are being included in Plan of Care and Kardex. Results of these audits will be reviewed and presented at the Quality Assurance Meeting for a three month period or until compliance determined by Quality Assurance Committee. D)Director of Nursing or designee will audit residents with a Wanderguard bracelet for 3 months to ensure accurate placement. Audits will be reported at the Quality Assurance Meeting. E)Director of Nursing or designee will review all residents Plan of Care who have the tendency for aggressive behaviors to ensure there is a plan of care in place for their behaviors. F)Director of Therapy Services will audit resident Plans of Care for updates on resident feeding status for 3 months or until compliance determined by Quality Assurance Committee results will be reported at Quality Assurance meetings. The following systemic changes have been	

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F 280	Continued From page 10 - 4/15/16 d/c (discontinue) Macrobid. Cipro (antibiotic medication) 250 mg po bid for 10 days. Review of laboratory (lab) tests revealed the results of a urinalysis (a lab test that provides important clinical information on kidney function) dated 4/11/16 showed the presences of nitrites (an enzyme in the urine that may indicate an infection) and the presences of leukocyte esterase (an enzyme produced by white blood cells in the urine that may indicate an infection). Review of a Final Microbiology Report dated 4/14/16 at 9:00 AM, revealed the resident's urine tested positive for a bacterial colony greater than 100,000 cfu/ ml (colony forming units/ milliliter) of Proteus mirabilis (a bacteria that causes UTIs). The Microbiology Report revealed that the bacteria in the urine was susceptible to Cipro and not susceptible to Macrobid. Review of the electronic CCP, revised 10/5/15, revealed a focus that documented the resident has occasional bladder incontinence related to a history of UTIs and limited mobility. The focus area also listed the following information: - 12/6/14 tx (treatment) for UTI - 1/22/15 tx UTI - 10/5/15 antibiotic for UTI The CCP was not revised to identify that the resident was diagnosed and treated for a UTI as of 4/12/16. Review of the certified nurse aide (CNA) Visual/Bedside Kardex Report (care guide) dated 4/21/16 revealed no direction for the use of Dycem on the wheelchair pad. During an interview with the Registered Nurse (RN) #2 Nurse Manager on 4/22/16 at 10:07	F 280	implemented to ensure continued compliance with this regulation: A)The Pharmacy Consultant, when generating recommendations to Physician for Gradual Dose Reductions(GDR) will also generate a communication to nursing of what the recommendation is and prompt to include the GDR and result on the residents Plan of Care. All nurses will be in serviced and educated on this new practice B)Location of placement of Wanderguard has been added to all Treatment Administration Records (TAR); Plan of Care and Kardex both indicate location. C)RN Nurse Managers will audit 20 additional residents care plan, closet care plan and kardex monthly for updated accurate information. The results of these audits will be reported and reviewed by facility interdisciplinary team until determined by team to be in compliance The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 280	Continued From page 11 AM, RN #2 stated that the recent UTI should have been added to the CCP and the use of Dycem should have been added to the Kardex. RN #2 stated that the CCP and Kardex should be updated by the nurse who receives an order for a new treatment. Review of the facility policy entitled "Interdisciplinary Care Plan," dated 2/2015 revealed that "changes shall be made to the Care Plan as changes occur with the resident. These changes shall be made by each department when necessary." Further review of the policy revealed that all Care Plans for residents of the facility must be current. 2. Resident #104 has diagnoses that include encephalopathy (a disease that affects the brain), advancing dementia and anxiety. Review of the MDS dated 3/9/16 revealed the resident has severe cognitive impairment, understands and is understood. During an observation of the resident on 4/20/16 at approximately 10:00 AM, the resident was sat up on the edge of the bed to speak with the surveyor. The resident was observed to have a Wanderguard on the left ankle. Review of the Physician's Orders, signed 4/21/16, revealed orders for a "roam alert bracelet" at all times, check placement. Review of the electronic CCP revealed the resident is an elopement risk/ wanderer and has impaired safety awareness. The resident has a history of attempts to leave the facility unattended. The intervention, dated 6/19/15, revealed, "New Wanderguard place left wrist 6/18/15. Nurse to check daily to ensure it is working correctly. CNA to check for placement	F 280		

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F 280	Continued From page 12 each shift." Further review of the CCP revealed the resident is and has potential to be physically aggressive related to dementia and a history of harm to others. The intervention, dated 12/10/15, revealed to monitor/ document/ report as needed any signs or symptoms of resident posing danger to self or others. Review of the CNA Visual/Bedside Kardex Report revealed in the section labeled Safety, "New Wanderguard place left wrist 6/18/15. Nurse to check daily to ensure it is working correctly. CNA to check for placement each shift." Further review of the Visual/Bedside Kardex Report revealed that staff are to complete 30 minute security checks, are to keep the resident in vision of staff member, are not to allow the resident to sit unattended in TV room, and to redirect re-approach resident if she becomes agitated. Additional instructions include to provide physical and verbal cues to alleviate anxiety, give positive feedback, assist resident to verbalize the source of agitation, assist to set goals for more pleasant behavior, encourage seeking out staff member when agitated. Staff are to distract resident from wandering, and accompany the resident any time she attempts to leave the unit. Review of the Treatment Administration Record (TAR) for February, March and April 2016 revealed the following instructions, "Roam alert bracelet at all times, check placement every shift, check function daily, replace one week prior to expiration." The TAR does not specify the location of the resident's Wanderguard bracelet.	F 280		

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F 280	Continued From page 13 Review of the electronic Progress Notes revealed the following: - An Incident Note written by a Licensed Practical Nurse (LPN) on 9/23/15 at 2:52 AM that at 10:45 PM the LPN observed Resident #104 push another resident and then placed that resident into a head lock. - An Incident Note written by the RN on 11/23/15 at 12:14 AM that the resident returned to facility at 10:30 PM via ambulance stretcher with two attendants. Settled in to her bed. Wanderguard reapplied to left ankle. Alert and responsive." - A Behavior Note written by a LPN on 1/25/16 at 11:26 PM that Resident #104 was yelling and swearing at a CNA. The LPN attempted to redirect the resident by calmly talking to the resident. The resident then attempted to run a wheelchair into the LPN. The nurse returned to the Nursing Station and Resident #104 approached the Nursing Station appearing confused. The LPN again attempted to calm the resident by talking with the resident. The resident started to scream and swear about not knowing who staff was or where she was at and grabbed writer (LPN) by the throat saying "I'll kill you." CNA got resident's hand free and attempted to put her (the resident) back into bed with negative effect. The CCP and Visual/Bedside Kardex Report did not address physically aggressive behaviors that the resident had exhibited on 9/23/15 and 1/25/16. In addition, the CCP and Bedside Kardex Report did not accurately document the placement of the resident's Wanderguard bracelet.	F 280		

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F 280	Continued From page 14 During an interview with the RN, Assistant Director of Nursing (ADON) on 4/25/16 at 10:01 AM, the ADON stated that the Bedside Kardex Report should address that the resident can be physically aggressive and the CCP and the Bedside Kardex Report should have been updated to reflect the current placement of the resident's Wanderguard. During an interview with the Medication Nurse (LPN) #3 on 4/25/16 at 10:10 AM, LPN #3 stated that she would write on the directions in the TAR the location of the Wanderguard if the information is not already included in the instructions. 3. Resident #59 has diagnoses which include dementia without behavioral disturbances, osteoarthritis, and anxiety. Review of the MDS dated 1/21/16 revealed the resident is severely impaired for decision making. Review of the Visual/Bedside Kardex Report revealed the resident eats breakfast in her room, lunch and supper in the independent dining room. The resident was observed on 4/19/16 at 12:46 PM and 4/21/16 at 12:15 PM eating lunch in the total assist dining room. The resident was observed on 4/20/16 at 8:30 AM and 4/21/16 at 8:35 AM eating breakfast in the total assist dining room. Interview with the Registered Dietitian (RD) on 4/21/16 at 12:45 PM revealed the resident is totally assisted at meals and eats all meals in the total assist dining room. The Occupational Therapist is responsible for updating the Care Plan for feeding status.	F 280		

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F 280	Continued From page 15 Review of the CCP revealed the resident recieves Seroquel (antipsychotic medication) due to a diagnoses of psychosis. The resident had a GDR (gradual dose reduction) on 6/22/15 that included a decrease in Seroquel to 25 mg at HS (bedtime). Review of Physician's Orders and the Medication Administration Records (MARs) dated 12/23/15 through 4/22/16 revealed the resident received Seroquel 50 mg at HS and Seroquel 25 mg prn (as needed). Interview with RN #2 on 4/22 at 9:00 AM revealed she is responsible for updating the Care Plans for the unit. She has been at the facility for six weeks and has been updating the Care Plans quarterly when there review is up. RN #2 stated when she gets to know the residents better she would make the changes when they occur. RN #2 stated, "I wasn't working at the facility in December when the Seroquel order changed."	F 280		
F 282 SS=D	415.11(c)(2)(iii) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during the Standard survey completed on 4/25/16, the facility did not ensure that services provided or arranged by the facility were provided by qualified persons in	F 282	The following corrective actions have been implemented for deficiency cited: A)Resident #34 was evaluated by Speech Language Pathologist(SLP) for the use of straws; it was determined resident is able to use straws. B)Resident #114 has been moved for meals to the Canal unit common area and is promptly put to bed after all meals. C)Director of Dietary in serviced dietary staff regarding differences in adaptive feeding equipment. D) Occupational Therapy evaluated resident #34 for appropriate use of adaptive devices.	06/17/2016

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F 282	Continued From page 16 accordance with each resident's written plan of care. Two (Residents #34, 114) of 22 residents reviewed for care plan implementation had issues involving the provision of straws and a section plate which were not in accordance with the care plan (#34) and a resident's feeding location and a plan to put the resident to bed after meals were not implemented as planned (#114). The findings are: 1. Resident #34 has diagnoses that include CVA (cerebrovascular accident - stoke), senile dementia, and dysphagia (difficulty swallowing). Review of the quarterly Minimum Data Set (MDS - a resident assessment tool) dated 3/2/16 revealed that the resident is cognitively intact, usually understands, and is usually understood. The resident MDS documented that the resident requires the supervision of one person to eat and drink and does not have swallowing difficulties. Review of a Speech Therapy Progress and Discharge Summary signed 2/16/16 revealed "Precautions" included Aspiration. The Discharge Plan and Instructions were to "continue with mechanical soft solids/thin liquids, alternate liquids and solids, slow rate of intake" Review of Physician's Orders dated 3/2/16 revealed orders for a mechanical soft diet with thin liquids. The orders included "No straws, Aspiration Precautions, give extra sauce/ gravy as needed, and least restrictive dietary consistencies". Review of the Quarterly Nutrition Care Area Assessment dated 3/4/16 revealed the resident's feeding ability was marked as "supervision".	F 282	The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A)Director of Therapy services or designee has audited Plan of Care for all residents identified as unable to use straws and/or have adaptive equipment for eating, to ensure this is reflected on Plan of Care and Kardex. B)Director of Dietary has audited all meal tickets to ensure they state "no straws" for those individuals unable to use them per Speech Language Pathologist (SLP). C)RN Nurse Managers audited all residents within the facility to ensure proper dining room placement. D)RN Nurse Manager audited all residents within the facility to ensues compliance with residents specifically identified as requiring the need to be put back to bed The following systemic changes have been implemented to ensure continued compliance with this regulation: A)Director of Dietary and Director of Therapy will meet quarterly to review those residents with adaptive devices to ensure devices remain appropriate as Plan of Care & Kardex state. B)An audit of all residents dining areas to ensure residents are appropriately located for meals will be conducted monthly by Director of Nursing of Designee C)AN audit of all residents requiring adaptive equipment, or restrictions (no straws) will be conducted monthly by Director of Nursing or designee D)An audit of all residents identified as requiring to be assisted back to bed will be conducted monthly by Director of Nursing	

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F 282	Continued From page 17 Comments included "section plate, liquids in two handled cup, no lid". The resident's swallow function was marked as "tolerate diet, monitor tolerance/ acceptance to altered consistency". Review of the current Comprehensive Care Plan revealed the following revisions: - 11/6/13 - "No straws" was initiated - 7/24/14 - "Aspiration Precautions" (measures to prevent food, liquids, and secretions from entering the lungs) were initiated - 4/14/15 - Consistency per SLP (speech language pathologist), food texture downgraded r/t (related to) dysphagia, thickened liquids provided, extra sauce/gravy as needed - 4/30/15 - Food texture upgraded per SLP, thickened liquids - 5/6/15 - Texture advanced per SLP regular, thin liquids - 1/22/16 - Adjusted meal plan for softer foods due to complaints of dentures hurting - 2/2/16 - SLP recommendations: mechanical soft consistency Review of the current electronic Kardex (used by the certified nurse's aides to provide care) revealed the following interventions: - Aspiration Precautions - Eating: setup and scoop plate; Eats breakfast, lunch and supper in TV room for increased supervision related to need for regular liquids. Mechanical soft solids, extra sauce/ gravy, alternate liquids/ solids, assistance in set-up thin liquids. - No straws - Resident to eat only with supervision Observation of the lunch meal in the supervision (TV) dining room on 4/19/16 at approximately	F 282	or designee E)The above audits will be reported and reviewed monthly by the facility Quality Assurance Committee for a minimum of 3 months or until determined by team to be in ongoing compliance The Director of Nursing will be responsible for overall monitoring, evaluation, and implementation of this plan.	

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F 282	Continued From page 18 12:30 PM revealed that the resident was eating mashed potatoes, chicken, and spinach from a section plate. The resident had a straw in one cup of a beverage. During an observation of a medication pass on 4/21/16 at 4:00 PM, a two handled cup with a straw in the cup and an insulated, lidded water mug with a straw in the cover was noted on the over-the-bed table in the resident's room. The Licensed Practical Nurse (LPN #4), who was passing medications, was observed to give the resident the insulated, lidded water mug to drink water when swallowing the medications provided. The resident used the straw to drink from the mug. During an observation of the breakfast meal in the supervision (TV) dining room on 4/22/16 at 8:27 AM, LPN #3 was observed to place straws in the cups of milk, juice, and coffee in front of the resident. The resident was observed eating scrambled eggs that were in a sectioned plate. Review of the resident's meal ticket for the breakfast meal on 4/22/15 revealed the resident was to receive a regular, mechanical soft diet using a sectioned plate and liquids in two handled mugs with no lid. The meal ticket did not identify the plan for "No Straws". During an interview with the Speech Language Pathologist (SLP) on 4/22/16 at 8:43 AM, the SLP stated that the resident did not use a straw during the last evaluation. The SLP stated that she did not think that the resident used straws. During the interview, the SLP was made aware that the resident was observed being given straws during meals and used a straw during a medication administration observation.	F 282		

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F 282	Continued From page 19 During an interview on 4/22/16 at 8:57 AM, the Occupational Therapist (OT) Director of Rehabilitation Services stated that staff should be following what is on the resident's Kardex. The OT stated that if the order is for "no straws", that should be followed. The OT stated, "We would need to re-evaluate to determine if she (the resident) can use straws." The OT stated that the dietary department probably changed the resident plate to a section plate because the resident received extra gravy and the section plate would stop it from mixing with other foods. The OT continued to state that the scoop and section plates are very similar but the OT would need to check on this and get a Physician's Order for an OT evaluation for the change in type of plate. During an interview on 4/22/16 at 9:07 AM, LPN #3 stated that the resident will request straws. LPN #3 stated "I did not know that she should not have straws". LPN #3 stated that the medication administration nurse should contact the charge nurse if a resident is requesting straws when there are orders to not have straws. During an interview on 4/22/16 at 9:17 AM, the Registered Nurse (RN) Nurse Manager stated that no staff member has told her that the resident is requesting straws. The RN Nurse Manager stated she has been working at the facility for six weeks and she would need to check if the resident is allowed straws. 2. Resident #114 has diagnoses of dementia, anxiety, blindness, and glaucoma. Review of the quarterly MDS dated 3/16/16 revealed that the resident has severe cognitive impairment, short and long term memory problems, is rarely understood, and rarely understands.	F 282		

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F 282	Continued From page 20 Review of the current Care Guide, used by CNA's to provide care, revealed approaches for the resident to eat breakfast, lunch, and dinner in the Canal View common area and be put to bed right after meals. Observation on 4/21/16, from approximately 12:15 PM to 12:42 PM, revealed that the resident was sitting in the Assist Dining Room during the lunch meal. Observations on 4/21/16 at 1:30 PM and 3:30 PM revealed the resident was lying in a fetal position in her Geri chair in her room. Observation on 4/21/16 from approximately 5:00 PM to 5:37 PM revealed that the resident was sitting in the Assist Dining Room during the dinner meal. Observation on 4/22/16 at approximately 1:30 PM revealed the resident was sitting in her Geri chair in her room after lunch. Interview with LPN #2 on 4/21/16 at approximately 3:43 PM revealed that the Canal View common area is the area where there are resident couches and not the Assist Dining Room. Interview with RN #1 on 4/21/16 at approximately 5:41 PM revealed that the common area of Canal View is the area in front of the CNA pod where there are couches. Interview with LPN #3 on 4/25/16 at approximately 8:29 AM revealed that "being put to bed right after meals" means that the resident should be put back to bed first before the other residents.	F 282		

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F 282	Continued From page 21 Interview with RN #1 on 4/25/16 at approximately 9:35 AM revealed that "being put to bed after meals means that when everyone is done with their meal they are the first to be put to bed". 415.11(c)(3)(ii)	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during the Standard survey completed on 4/25/16, the facility did not provide the necessary care and services to attain and maintain the resident's highest practicable well being. One (Residents #71) of 2 residents reviewed for quality of care had issues involving positioning in a special chair that did not fit the resident properly. The anti-tipping chair was too short for the dining table and the resident was often observed leaning to the left over the armrest. The findings is: 1. Resident #71 has diagnoses which include Alzheimer's disease, anxiety disorder, and diabetes mellitus. Review of the Minimum Data Set (MDS-a resident assessment tool) dated 2/24/16 revealed the resident is severely	F 309	The following corrective actions have been implemented for the deficiency cited: A)Resident #71 has been issued a new wheelchair and positioning devices. B)Plan of Care established for resident #71 new wheelchair and positioning devices. The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A)The Therapy Director has audited all residents with specialty chairs and positioning devices to ensure all devices have been Care Planned for including the Kardex. Audits will be conducted on all new residents picked up by Therapy to ensure Care Planning of devices for 3 months and results reported to the Quality Assurance meetings. B) Director of Therapy has in serviced nursing staff on proper positioning for feeding. The following systemic changes have been implemented to ensure continued compliance with this regulation: A)The Director of Therapy or Designee will in-service staff annually and when new devices are instituted, on proper positioning of residents with specialty chairs and positioning devices and keep records of this for yearly in-servicing	06/17/2016

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(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) COMPLETE DATE
F 309	Continued From page 22 impaired for decision making. The resident was observed on 4/19/16, 4/20/16, 4/21/16, and 4/22/16 positioned in a specific chair that angles back. Interview with the PT on 4/22/16 at 1:25 PM revealed the chair is an anti-tipping chair generally used for dementia residents to keep them from falling out. The resident was observed on 4/19/16 at 11:55 AM in the total assist dining room seated in the anti-tipping chair at the dining table. The chair was so low to the table the resident's mouth was level with table. The resident was observed leaning over the left side of the chair on 4/20/16 at approximately 9:15 AM and at 9:50 AM she was observed with a pillow between her left shoulder and the arm of the chair. The resident was observed on 4/21/16 at 12:19 PM (lunch) and again on 4/21/16 at 5:25 PM (dinner) in the total assist dining room seated in the anti-tipping chair at the dining table. The chair was so low to the table the resident's mouth was level with table. The resident was intermittently observed during those meals being fed periodically at a 25-45 degree angle. The resident was observed on 4/21/16 at 9:30 AM through 11:40 AM in the hallway sitting in the anti-tipping chair leaning to left side over the armrest. There was no pillow or bolster between her left side and the chair. This was brought to the attention of the Physical Therapist (PT) by the surveyor on 4/21/16 at approximately 2:00 PM. The PT asked the certified nurse aide (CNA) about the resident's positioning. The	F 309	requirements. B)All residents will be reviewed by therapy for proper seating and proper positioning with each care plan review. The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 309	Continued From page 23 CNA stated, "Sometimes we put a pillow there when she is leaning to the left." The PT stated that there is no Care Plan for the use of the anti-tipping chair or use of pillows/bolsters. She stated the chair is too low for the table but it angles back to prevent the resident from tipping out. During an interview on 4/25/16 at 10:00 AM the Registered Nurse (RN) Director of Nursing (DON) stated, "The resident has been in that chair for three years. It's the only way they can keep her from falling on her face." Interview with the Social Worker on 4/20/16 at 1:30 PM revealed the resident was moved from the locked Dementia Unit about three weeks ago because it is no longer required. The resident is nonambulatory now and is not active like she use to be. Interview with the Occupational Therapist (OT) on 4/21/16 at approximately 2:30 PM revealed PT shared positioning concerns with her and she planned to do an evaluation tomorrow. Review of a PT/OT note dated 4/22/16 at 10:30 AM revealed a positioning evaluation was completed during meals. Resident required consistent assistance for repositioning to ensure safety at meals. Skilled OT intervention will attempt to improve functional positions during meals and other activities. 415.12	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312	The following corrective action has been implemented for the deficiency cited: A)Resident #1 was properly re bathed and rinsed accordingly. B)Residents #1 & # 54 were assessed by RN and found to have no ill effect from this	06/17/2016

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F 312	Continued From page 24 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during a Standard survey completed on 4/25/16, the facility did not ensure that a resident who is unable to carry out activity of daily living (ADLs) receives the necessary services to maintain grooming and personal hygiene. Two (Residents #1, 54) of five residents observed for morning care had issues with the certified nurse aide (CNA) did not wipe soap off the resident prior to drying the resident and did not change gloves or wash hands after providing incontinence care and applying a new brief (Resident #1); the CNA did not wash hands or change gloves after removing a visibly wet brief from the resident then applied lotion to the resident's back (Resident #54). The findings are: 1. Resident #54 has diagnoses of dementia and dysphagia (difficulty in swallowing). Review of the quarterly Minimum Data Set (MDS - a resident assessment tool) dated 1/26/16 revealed that the resident has a long and short term memory problem, has no speech, rarely understands, and needs a one person physical assist with bathing. The resident was observed on 4/22/16 at 6:22 AM receiving AM (morning) care. CNA #1 washed and dried the resident's front peri area (area between the the anus and genitalia) and then began to remove the resident's brief. When asked if the resident's brief was wet, CNA #1 replied "yes, the brief is wet. See?" and showed the wet brief to the surveyor. CNA #1 then	F 312	incident C)Label placed on resident #54 personal body soap the states: "Must be rinsed off". D)All nursing staff were in serviced on proper hand hygiene. The following actions have been completed to identify other residents within the facility that have potential to be affected by this deficiency: A)The Director of Nursing or designee will conduct weekly Audits for 3 months or until compliance determined by Quality Assurance Committee on all units during A.M. and H.S. care to ensure proper hand washing and proper use of personal hygiene products; results will be reported to Quality Assurance Meetings. The following systemic changes have been implemented to ensure continued compliance with the regulation: A)A Policy has been written on personal care products purchased outside of the facility and all nursing staff have been in serviced on this policy. The Director of Nursing will be responsible for implementation and evaluation of this corrective action	

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F 312	Continued From page 25 applied lotion to the resident's back. CNA #1 did not change gloves or wash hands prior to applying the lotion and finishing AM care. During an interview on 4/22/16 at 6:42 AM CNA #1 stated, "I should've changed my gloves and washed my hands after I removed the resident's wet brief." During an interview on 4/22/16 at approximately 11:40 AM the Registered Nurse (RN) #2 revealed that she expects her staff to change their gloves after removing a wet brief and before they touch another part of the resident's body. During an interview on 4/22/16 at 11:44 AM the Infection Control Nurse RN #1 revealed that she expects staff to remove their gloves, sanitize their hands, and put on new gloves after they remove a wet brief. 2. Resident #1 has diagnoses which include Stage 3 pressure ulcer of the sacrum (area above the tail bone on the right and left buttocks) and right buttock, diabetes mellitus, and congestive heart failure (CHF). Review of the MDS dated 2/17/16 revealed the resident is cognitively intact, is understood and understands. The resident requires physical help in part of bathing activity of two or more persons physical assist. Observation of AM care on 4/21/16 at approximately 9:40 AM revealed CNA #7 used the resident's personal body wash to perform AM care. CNA #7 applied the body wash to a wash cloth, lathered and cleansed the resident's upper extremities, lower extremities and back. CNA #7 then dried the resident's upper extremities, lower extremities and back without	F 312		

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F 312	Continued From page 26 rinsing off the lather. CNA #7 then applied lotion to all areas. Review of the body wash directions revealed, "For daily use in bath and shower. Squeeze body wash onto a wash cloth or puff. Lather and rinse off." During an interview on 4/21/16 at 10:14 AM CNA #7 stated, "I didn't rinse the soap off. The facility uses a no rinse product. I should've rinsed off the soap." Continued observation of AM care revealed CNA #7 removed the resident's brief as the resident was having a bowel movement. CNA #7 then wiped the resident's anal area and washed the resident's buttocks, leaving a brown smear on the wash cloth. CNA #7 then applied a clean brief, removed her gloves, and continued with care. During an interview on 4/21/16 at 10:14 AM CNA #7 stated, "I should've changed my gloves and washed my hands after incontinent care." Review of facility policy and procedure entitled "Hand Hygiene" revision dated 3/2/10 included the following: -All personnel shall wash their hands to prevent the spread of infection and disease to other personnel, residents, and visitors. -Appropriate 15 second handwashing must be performed after and in some cases before the following conditions: -After giving incontinence care. 415.12(a)(3)	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	The following corrective action has been implemented for the deficiency cited: A)Resident #1, all linen except fitted sheet	06/17/2016

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F 314	Continued From page 27 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE ABBREVIATED SURVEY COMPLETED ON 10/13/15. Based on observation, interview, and record review conducted during the Standard survey completed 4/25/16, the facility did not ensure that residents having pressure ulcers receive the necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing. Two (Residents #1, 102) of three residents reviewed for pressure ulcers had a seven day delay in the initiation of a treatment to a pressure ulcer, and there was no evidence of weekly Registered Professional Nurse (RN) assessment to include the type of ulcer, measurements, staging and wound characteristics (Resident #102); and preventative measures were not in place as care planned (Resident #1). The findings are: 1. Resident #102 was admitted to the facility on 1/5/16 with diagnoses that include diabetes mellitus (DM), anemia, and S/P (status post) right hip fracture with surgical repair. Review of	F 314	and draw sheet were removed off the Alternating low pressure mattress. B)Resident #1 plan of care was updated to include fitted sheet and draw sheet only on bed; no brief in bed. C) Resident #102 was assessed by RN, with wound and treatment documentation updated The following actions have been completed to identify other residents within the facility that have potential to be affected by this deficiency: A)The Director of Nursing or designee will perform weekly audits of alternating low pressure mattresses in facility. Audits will be done for 3 months or until compliance determined by Quality Assurance Committee to ensure proper linen is being placed on these mattresses. Results reported to Quality Assurance meetings. B)All nursing staff have been in serviced on the proper linen to be placed on alternating low pressure mattress. C) All Nurses, LPN and RN have been in serviced on head to toe assessment and collection of documentation on new admission skin data collection form, weekly skin documentation, and obtaining order upon admission for treatment of any wounds found. The following systemic changes have been implemented to ensure continued compliance with the regulation: A)A revised policy for wound care has been written that includes wound data collection upon admission. All nursing staff have been in serviced on this revised policy. B) A policy has been written for the use of low pressure alternating mattresses. All nursing staff have been in serviced on this	

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F 314	Continued From page 28 the Minimum Data Set (MDS - a resident assessment tool) dated 1/12/16 revealed the resident is cognitively intact, is understood and understands. The resident has one Stage 2 pressure ulcer present upon admission. Review of the Medical Record revealed no documented evidence of a Stage 2 pressure ulcer from 1/5/16 through 1/8/16. Review of the Nurse Practitioner (NP) Wound Consultant note dated 1/8/16 included the following: -Physical Exam: Partial - thickness wound of the left heel. 3.0 cm (centimeter) x (by) 3.0 cm x 0.0 cm. Fluid filled blister. No drainage. Wound edges adherent to wound base. Periwound (area surrounding the wound) without erythema (redness), induration (hardening of a normally soft tissue or organ), edema (swelling caused by excess fluid accumulation), or crepitus (grating, crackling, or popping sounds experienced under the skin and joints). Patient does not demonstrate evidence of pain when affected area palpated. -Plan: Stage 2 pressure ulcer of the left heel - blister: Cleanse with normal saline (NS) or wound cleanser. Apply Skin Prep (topical application that "toughens" skin and enhances adherence of dressing) daily. Encourage bilateral heel booties. Float left heel on pillows. Continue repositioning in accordance to facility policy, off-load pressure on area. Monitor nutritional intake. Review of a Physician's Order dated 1/13/16 revealed an order to cleanse Stage 2 of (left) heel blister with NS and apply Skin Prep daily.	F 314	policy. C)All residents will be seen by an RN on admission for skin impairments, any impairment will be referred to the skin team for follow up. D) ADON/RN designee will audit all residents will skin impairments and document findings in the residents medical record on a weekly basis based on facility policy. The Director of Nursing will be responsible for implementation and evaluation of this corrective action.	

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F 314	Continued From page 29 Review of a Treatment Administration Record (TAR) revealed the treatment to cleanse Stage 2 pressure area (blister) L (left) heel with NS and apply Skin Prep daily was initiated on 1/14/16. Review of the Medical Record revealed no treatment was administered to the left heel Stage 2 pressure ulcer from 1/8/16 through 1/13/16. Interview with the RN Director of Nursing (DON) on 4/22/16 at approximately 11:05 AM revealed, "I would expect an order to be obtained, and a treatment in place as soon as an area is identified." Additional review of the Medical Record revealed that weekly RN assessments did not include the type of ulcer, measurements, staging and wound characteristics. Review of Patient Visit Records by the Wound Consultant revealed the resident was seen on 1/8/16, 1/22/16, 1/29/16, 2/5/16, 2/9/16, and 2/16/16. Further review of the 2/16/16 Wound Consultant note revealed the left heel pressure ulcer was resolved. Review of the Medical Record revealed there were no further RN assessment of the left heel. Interview with the DON on 4/22/16 at approximately 11:05 AM revealed an area that has been resolved should be monitored for "a good 30 days after its been resolved to make sure it stays resolved." 2. Resident #1 has diagnoses which include Stage 3 pressure ulcer of the sacrum (area above the tailbone on the right and left buttocks) and right buttock, DM and congestive heart	F 314		

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F 314	Continued From page 30 failure (CHF). Review of the MDS dated 2/17/16 revealed the resident is cognitively intact, understands and is understood. The resident has two Stage 3 pressure ulcers. In addition, the MDS documents the resident has a pressure reducing device for bed. Review of the Wound Consultant Note dated 4/13/16 included "Interventions in place: air mattress." Review of the certified nurse aide (CNA) Visual/Bedside Kardex Report (care guide) included the following: -Bariatric (treatment of obesity) alternating pressure mattress and bed cradle (device attached to foot of bed that keeps sheet and blankets from touching and rubbing the legs and feet) on bed. -No soaker pad on bed. No fitted sheet on bed. No brief on while in bed. Resident only to have draw sheet between mattress and buttocks while in bed. -Turn and position every two hours. Side to side only. No pillows, no wedges. Observation of the resident on 4/20/16 at approximately 9:40 AM revealed the resident was lying on an alternating air mattress with a bed cradle and no draw sheet. In addition, a fitted bed sheet, soaker pad, wedge on left side of resident and a pillow on the right side of the resident was observed. During an interview on 4/21/16 at approximately 10:58 AM the DON stated, "The Kardex is used by the CNAs to know the plan of care for the resident." In addition, the interview revealed the expectation is for all staff to follow the Kardex.	F 314		

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F 314	Continued From page 31 Review of the undated Low Air Loss Mattress Systems Operational Manual clarification revealed, "The zippered cover is composed of a soft nylon material, which combines softness, low shear and high moisture vapor transmission to assist in reducing injury to the patient's skin. The patient may lie directly on this nylon cover. If desired a breathable sheet (cotton) may be placed on top of the cover. A breathable sheet will not alter the performance of the low air loss system, however, anything thicker may prevent the air from escaping from the top of the mattress, therefore reducing the efficiency of moisture vapor transmission. " 415.12(c)(2)	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during the Standard survey completed on 4/25/16, the facility did not ensure that a resident with a limited range of motion (ROM) receives appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM. One (Resident #59) of one resident observed for splint application lacked a right palm guard in place as planned to prevent worsening contractures from occurring.	F 318	The following corrective action has been implemented for the deficiency cited: A)Director of Therapy services immediately placed a rolled washcloth in resident #59 hand. The missing right palm guard splint was replaced with a new palm guard splint. The following actions have been completed to identify other residents within the facility that have potential to be affected by this deficiency: A)The Director of Therapy or Designee audited all residents with splints to prevent contractures to ensure all those residents have the splints assigned to them, and that they are being applied properly. B)The Director of Therapy or designee has in-serviced all nursing staff regarding who to notify when they can not find a splint, and the importance of splint application. The following systemic changes have been implemented to ensure continued compliance with the regulation:	06/17/2016

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F 318	Continued From page 32 The finding is: 1. Resident #59 has diagnoses which include dementia without behavioral disturbances, osteoarthritis, and anxiety. Review of the Minimum Data Set (MDS - a resident assessment tool) dated 1/21/16 revealed the resident is severely impaired for decision making. Interview with the Licensed Practical Nurse (LPN) #1 on 4/19/16 at 11:00 AM revealed the resident has contractures of the right hand and wrist. The resident uses a right palm guard at all times except hygiene. Review of the certified nurse aide (CNA) Visual/Bedside Kardex Report (care guide) revealed SPLINTING: right palm guard on at all times. HYGEINE: cleanse palms two times daily. If resident resists with ADL's, (activity of daily living) reassure resident, leave and return five to ten minutes later and try again. The resident was observed intermittently on 4/19/16 through 4/22/16 from 7:45 AM through 3:45 PM without the right palm guard. Observation of the resident in her room on 4/22/16 at approximately 10:30 AM with the Occupational Therapist (OT) revealed there was no splint in place per the Care Plan. Further observation of the resident room by the OT revealed the right palm guard could not be found in the resident's room. The OT attempted to open the resident's hand to look at her palm with difficulty. The OT was able to open it enough for the surveyor to observe indentations in the resident's palm from her fingernails. There was no skin breakdown.	F 318	A)The Director of Therapy or Designee will do weekly audits to ensure all residents care planned for splints have them and that they are being used properly. The results of these audits will be reported in Quality Assurance Meeting. The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 318	Continued From page 33 Interview with the OT on 4/22/16 at approximately 10:35 AM revealed she was not aware the resident was not wearing the right palm guard and planned to try alternate items to minimize contractures and skin breakdown. 415.12(e)(2)	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during the Standard survey on 4/25/16, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents. One (Resident #71) of six residents reviewed for accidents, at risk for aspiration (taking foreign matter into the lungs), was not positioned in a manner that was conducive for eating/ swallowing and was coughing/ choking intermittently throughout meals. The finding is: 1. Resident #71 has diagnoses which include Alzheimer's disease, dysphagia (difficulty swallowing), anxiety disorder, and diabetes mellitus. Review of the Minimum Data Set (MDS - a resident assessment tool) dated 2/24/16 revealed the resident is severely impaired for decision making.	F 323	The following corrective actions have been implemented for the deficiency cited: A)Resident #71 has been issued a new wheelchair and positioning devices. B)Plan of Care established for resident #71 new wheelchair and positioning devices. The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A) Director of Therapy has in-serviced nursing staff on proper positioning for feeding. B)Director of Therapy and Director of Nursing audited all dinning rooms to identify any other residents at risk of having potential to be affected by this practice. The following systemic changes have been implemented to ensure continued compliance with this regulation: A)The Director of Therapy or Designee will in-service staff yearly and when new devices are instituted, on proper positioning of residents while feeding, and keep records of this in-service for in-servicing requirements. B)The Speech Language Pathologist has in-serviced all nursing staff on signs and symptoms of a resident choking/aspirating while feeding on an on going basis. The Director of Therapy will keep records of	06/17/2016

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F 323	Continued From page 34 Review of the Comprehensive Care Plan revealed the resident has dysphagia and swallowing problems due to the loss of food and fluid while eating. Resident has issues with pocketing food in her mouth and receives a puree diet with honey thick liquids. Interventions include to monitor for aspiration, coughing drooling, holding food in mouth, and use several attempts at swallows. All staff to be aware of resident's special dietary and safety needs. The resident was intermittently observed on 4/19/16, 4/20/16, 4/21/16, and 4/22/16 positioned in a specific chair that angles back. Interview with Physical Therapist (PT) on 4/22/16 at 1:25 PM revealed the chair is an anti-tipping chair generally used for dementia residents to keep them from falling out. The resident was observed on 4/19/20 at 11:55 AM in the total assist dining room seated in the anti-tipping chair at the dining table. The chair was so low to the table the residents mouth was level with table. This was observed on 4/21/16 at 12:19 PM (lunch) and again on 4/21/16 at 5:25 PM (dinner). The resident was observed during those meals being fed periodically at a 25 to 45 degree angle, coughing while being fed. During observation of the lunch meal on 4/19/16 at 12:28 the resident was observed in a semi supine position (25 to 45 degrees) being fed by staff. The resident was observed coughing and almost vomited. The staff wiped the resident's mouth and continued to feed her. Later observation at 12:34 PM the resident started making a retching noise and the staff member waited until the noise stopped and gave more food.	F 323	this in-service for in-servicing requirements. C)The Director of Therapy or designee has compiled a list of residents on aspiration precautions and will keep The Director of Dietary updated on new residents placed on aspiration precautions. The residents meal ticket will state "ASPIRATION PRECAUTIONS" D) A monthly Audit will be completed by DON or designee on proper positioning of all residents. The results of this audit will be presented and reviewed by the facility Quality Assurance Committee until determined by team that facility has ongoing compliance The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 323	Continued From page 35 Interview with PT on 4/21/16 at approximately 2:00 PM revealed the resident should be boosted up right during meals. Review of an Occupational Therapy (OT) evaluation dated 4/22/16 revealed the resident requires consistent assistance for repositioning to ensure safety while eating. Requires total assistance for feeding to bring cup to mouth and spoon to mouth. During fluid intake resident frequently bit the cup. Skilled OT intervention will attempt to improve functional positions during meals and other activities. 415.12 (h)(1)	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	The following corrective actions have been implemented for the deficiency cited: A)Resident #59 Seroquel 25mg pm q4h was discontinued per MD order. B)LPN who gave pm Seroquel has been educated on the proper use of this antipsychotic med and proper documentation. The following actions have been completed to identify other residents within the facility that have potential to be affected by this deficiency: A)A review of all MAR's has been conducted by the Assistant Director of Nursing. All PRN antipsychotics that have not been used more than 5 times per month have been presented to M.D. and DC'd; any PRN antipsychotic that are being used in excess of 5 times per month have been presented to M.D. for a daily scheduled dose of that drug or DC'd per M.D. order. B) All nurses have been in-serviced on the proper use of pm antipsychotic meds and proper documentation of their use. The following systemic changes have been	06/17/2016

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F 329	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during the Standard survey completed 4/25/16, the facility did not ensure that each resident's drug regimen must be free from unnecessary drugs. One (Resident #59) of six residents reviewed for unnecessary drugs had an as needed (PRN) antipsychotic medication ordered for agitation but was administered the medication for anxiety caused by the repetitive actions of another resident. . The finding is: 1. Resident #59 has diagnoses which include dementia without behavioral disturbances, osteoarthritis, and anxiety. Review of the Minimum Data Set (MDS - a resident assessment tool) dated 1/21/16 revealed the resident is severely impaired for decision making. Review of admission Physician's Orders dated 12/23/15 revealed the resident is to receive Seroquel 50 milligram (mg) by mouth (po) at bedtime (HS) and Seroquel 25 mg prn every four hours for agitation. Review of the Medication Administration Record (MAR) revealed the resident received zero prn doses in December 2015, five prn doses in January 2016, five prn doses in February 2016, one prn dose in March 2016, and one prn dose in April as of 4/21/16. Review of a Progress Note dated 3/29/16 sign by Licensed Practical Nurse (LPN) #3 revealed, "Gave Seroquel at 3:00 PM for increased anxiety related to repetitive actions of another	F 329	implemented to ensure continued compliance with the regulation: A)A policy has been written limiting the use of prn antipsychotic medication to a 2 week period. If the resident has been administered the prn med 3 times or more weekly during the 2 week period, the M.D. will be contacted for a routine dose and prn dose DC'd; if this criteria is not met, the prn med will be DC'd and no routine order will be obtained. B) Pharmacy Consultant will audit monthly residents orders for PRN (as needed) psychotropic medication use. The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 329	Continued From page 37 resident. Quiet at 4:00 PM." Interview with the Registered Nurse (RN) Assistant Director of Nursing (ADON) on 4/22/16 at 9:10 AM revealed this was not an appropriate use of the prn Seroquel. Interview with the Consultant Pharmacist on 4/22/16 at 10:50 AM revealed a prn dose of Seroquel is appropriate if used less than five to six times a month. The prn Seroquel should be used if a resident is at risk of injuring self or others. It is not appropriate to administer prn Seroquel to a resident because of the behavior of another resident. "It would seem some in-servicing needs to be done for the nurses on medication administration and documentation." 415.12(l)(1)	F 329		
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by:	F 368	The following corrective action was implemented for the deficiency cited: A)At Resident Council Meeting on 5/2/16, residents were asked if they wanted changes in their meal times. Residents responded they would like their meal times to stay the same. The following actions have been completed to identify other residents within the facility that have potential to be affected by this deficiency: A)The Director of Nursing or designee will conduct nightly audit for 1 month or until compliance determined by Quality Assurance Committee to ensure HS nourishments are being passed by 8pm nightly on all units. The results of these audits will be reported to Quality Assurance Meeting. B)All nursing staff have been in-serviced by the Food Service Director regarding the difference between HS nourishments and	06/17/2016

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F 368	Continued From page 38 THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 2/6/15. Based on interview and record review conducted during the Standard survey completed 4/25/16, the facility did not ensure that a substantial nourishing snack is offered to all residents when there is a greater than a 14 hour lapse between the dinner meal and breakfast and did not have approval of the current resident group. The finding is: 1. Review of meal time sheets provided by the Food Service Director (FSD) on 4/20/16 at approximately 8:30 AM revealed the Autumn North Unit receives there first dinner cart at 4:40 PM and their first breakfast cart at 7:15 AM. This results in a span of 14 hours and 35 minutes. The Main Dining Room receives Dinner from 5:15 PM to 5:30 PM and Breakfast from 8:10 AM to 8:25 PM. This results in a span of 14 hours and 55 minutes between the dinner and breakfast meal. Review of the Resident Council Committee minutes dated April 2015 through April 2016 revealed a lack of documentation the meal times were approved by the Resident Council. Interview with the Resident Council President on 4/22/16 at 9:40 AM revealed nobody had asked the Resident Council group if they approved of the meal times. The Resident Council President also stated she is supposed to get a snack at night (HS) and did not get one last night. Additionally, the staff did not pass the HS snacks until 9:00 PM the other night and most of the residents were asleep.	F 368	bulk food items stored in the kitchenette for HS snacks. The following systemic changes have been implemented to ensure continued compliance with the regulation: A)The Food Service Director has developed a "Substantial Snack's Provided" form for documenting bulk snacks that are given to residents in the night between dinner and breakfast meals. All nursing staff have been in-serviced on this form. B)The Director of Activities will ensure that resident's are asked quarterly at Resident Council Meeting if they desire a change in meal times. Their response will be reported in the Resident Council Meeting minutes. The Director of Nursing will be responsible for implementation and evaluation of this corrective action	

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F 368	Continued From page 39 Interview with the FSD on 4/22/16 at 9:35 AM revealed she provides bulk food items for the units for HS snacks if a resident wants one but is not aware if staff are actually offer an HS snack to all residents. Additionally, there is no documentation HS snacks are being offered, accepted, or refused to all residents. 415.14(f)(2-4)	F 368		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during the Standard survey completed 4/25/16, the facility did not provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident. One (Resident #59) of 6 residents	F 425	The following corrective action was implemented for the deficiency cited: A)The MD for resident #59 was contacted on 4/25/16 to clarify Norco order; order was clarified by MD to read: Norco 5/325mg 1 tablet by mouth every 4 hours as needed for pain rated 5-10 on pain scale. The following actions have been completed to identify other residents within the facility that have potential to be affected by this deficiency: A)A review of all resident's MAR's (med administration record)was performed by the Director of Nursing or designee to identify any other resident's who's pain med administration is not based on pain scale 1-10. B)All nurses were in-serviced on transcribing MD orders and obtaining clarification for pain med if order does not include pain scale parameters for administration. The following systemic changes have been implemented to ensure continued compliance with the regulation: A)The pain management policy was revised by the Director of Nursing to include 2 week parameter for prn pain meds. If resident has taken pain med more than 3 times weekly during the 2 week period, MD will be contacted for a routine	06/17/2016

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F 425	Continued From page 40 reviewed for unnecessary medications had issues involving the lack of pharmaceutical services to assure that medications are properly labeled when dispensed. The finding is: 1. Resident #59 has diagnoses which include dementia without behavioral disturbances, osteoarthritis, and anxiety. Review of the Minimum Data Set (MDS-a resident assessment tool) dated 1/21/16 revealed the resident is severely impaired for decision making. Review of a Physician's Order initiated on 12/23/15 revealed an order for Norco (narcotic pain medication) give 1 tablet po (by mouth) Q4H (every four hours) prn (as needed) leg/hip pain. Review of a Physician's Order dated 3/26/16 revealed an order for Norco give 1 tablet po Q4H prn leg/hip pain. Review of a January and February 2016 Pain Flow Sheets revealed Norco was administered on 1/12, 1/13, 1/14, 1/16, 1/17, 1/25, and 1/28 for generalized pain and on 2/8 and 2/9 for shoulder pain. Review of a Progress Note dated 3/8/16 revealed documentation the resident has a standing order for Norco for right shoulder pain. Further eview the Physician's Orders dated dated 3/26/16 revealed a lack of documentation the Norco was for shoulder pain. During an interview on 4/22/16 at 9:10 AM the Registered Nurse (RN) Assistant Director of Nursing (ADON) revealed that the Norco order	F 425	order and MD will at that time determine if prn order will stay in place with routine med or be Discontinued. B) Audit will be completed by ADON or designee on all AS needed (PRN) pain medications monthly and with all new orders for pain medication. Results will be reported to the Quality Assurance Committee. The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 425	Continued From page 41 should have been clarified with the Physician. When the resident returned from the hospital she had issues with her hip and leg. The resident later developed a shoulder abscess causing her pain. During an interview on 4/22/16 at 10:50 AM the Consultant Pharmacist stated, "The Norco order for prn leg and hip pain should've been clarified with the Physician. They're just shooting themselves in the foot for making the order that specific." 415.18(a)	F 425		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during a complaint investigation (Complaint #NY00178230) during the Standard survey completed on 4/25/16, the facility did not maintain clinical records on each resident in accordance with acceptable professional standards and practices that are complete; accurately documented; readily accessible; and	F 514	The following corrective action was implemented for the deficiency cited: 1) Director of Nursing and facility Medical Director did review complete medical record for resident #156 2)Director of Nursing further investigated to identify specific Licensed Nurse who was on duty for resident #156 on 6/16/15. However, this nurse is no longer with the facility. 3)In servicing/reeducation was provided to all licensed nursing staff regarding medication changes associated with abnormal lab values. The following actions have been completed to identify other residents within the facility that have potential to be affected by this deficiency: 1)A review of all residents receiving KCL (potassium chloride)within the facility was completed by Registered Nurse Managers. The following systemic changes have been implemented to ensure continued compliance with the regulation: 1)A daily audit of MAR's (medication	06/17/2016

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F 514	Continued From page 42 systematically organized. One (Resident #156) of one resident's medical records reviewed for complete and accurate documentation had issues. Specifically, Potassium Chloride (used to prevent or to treat low blood levels of potassium) 40 mEq (milliequivalents) was not initialed as given by nursing on the Medication Administration Record (MAR) on 6/16/15 per the Nurse Practitioner's (NP) Orders after the dosage was increased based on laboratory results. The finding is: 1. Resident #156 has diagnoses including anemia, GERD (gastroesophageal reflux disease-backflow of gastric juices into the esophagus), and depression. Review of laboratory (lab) test result dated 6/15/15 revealed the potassium level was 2.5 low (normal range is 3.5-5.1). Review of a Telephone Order dated 6/15/15 at 4:30 PM revealed to increase KCl (potassium chloride) to 40 mEq (milliequivalents) po (by mouth) for five days then resume KCl 20 mEq po daily. Review of the MAR dated June 2015 revealed the KCl 20 mEq is initialed as administered from 6/5/15 through 6/15/15. From 6/16/15 through 6/20/15 there is an "H" written in the boxes. The KCl 40 mEq is not initialed as given on 6/16/15. The resident was sent to the hospital on 6/17/15 early morning. Review of a Physician Progress Note from the hospital dated 6/17/15 revealed that at 11:37 AM the resident's potassium level was 2.6 low.	F 514	administration record) conducted by Nursing Management to ensure all medications have been properly initialed or otherwise explained 2)Results of the MAR audits will be presented and reviewed during the facility monthly Quality Assurance Committee meeting for 3 months or until compliance determined by Quality Assurance Committee to further identify compliance The Director of Nursing or designee will be responsible for implementation and evaluation of this corrective action	

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F 514	Continued From page 43 During an interview on 4/22/16 at 1:36 PM the Registered Nurse (RN) Director of Nursing (DON) reviewed the June 2015 MAR and stated that she does not know if the resident received the potassium on 6/16/15 per the order. The DON further stated she would call the Pharmacy to see if they have any documentation tracking the delivery and use of the medication. During further interview on 4/25/16 at 1:40 PM the DON stated she received some documents from the Pharmacy but they do not show if the resident received the potassium 40 mEq or not. No further documentation was provided regarding the potassium chloride administration. 415.22(a)(1-4)	F 514		

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K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1. This STANDARD is not met as evidenced by: Based on observation during a Life Safety Code survey completed 4/25/16, a fire barrier wall was not complete from floor to ceiling/ roof deck, was not designed to have at least a two hour fire resistance rating and was not designed to resist the passage of fire and smoke. This affected one of one fire barrier wall located between the new (2006 building) and the existing (1970, 1989) buildings. The findings are: 1. Observation above the ceiling tiles on 4/20/16 at approximately 9:26 AM revealed an approximate two inch long by two inch wide penetration through the fire barrier wall that separated the new (2006 building) from the existing (1970, 1989) buildings was filled with mineral wool that was not sealed with a fire rated material. Further observation at this timer revealed this penetration was located above the corridor fire barrier doors that separated the Villages dining room from the corridor near the locker room, on the locker room side of the doors. 2. Observations above the ceiling tiles, of the fire barrier wall, located above the fire barrier doors, that separated the new (2006 building) from the existing (1970, 1989) buildings on the Villages dining room side of the doors on 4/20/16 at approximately 11:40 AM revealed the following: - One, two inch long by one quarter of an inch	K 012	The following was accomplished for the deficiency cited: 1)The two inch long by two inch wide penetration through the fire barrier wall that separated the new (2006 building)from the existing (1970, 1989 buildings)was sealed with a fire rated material. 2)The fire barrier wall, located above the fire barrier doors repaired the following: - One two inch long by one quarter inch hole was sealed with a fire rated material. - One ten inch long by one half inch wide open penetration was sealed with a fire rated material. - The ten inch long by three inch wide open penetration was sealed with a fire rated material. - The three inch long by two inch wide penetration filled with mineral wool that was not sealed with a fire rated material. - An eight inch long by three inch wide penetration filled was sealed with a fire rated material. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected. 1)A visual inspection of the fire barrier wall will be completed during all projects above the ceiling tiles. The following systemic changes have been implemented to assure continued compliance with the regulation: 1)A monthly inspection audit of all smoke barrier walls within the facility will be conducted by the Director of Maintenance or designee. 2)Any and all identified smoke barrier penetrations will be immediately and properly sealed by the Director of	06/17/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/26/2016

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	335212	A. BUILDING 03 - 2006 BUILDING B. WING _____	04/25/2016

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K 012	Continued From page 1 wide open unsealed penetration above an insulated pipe installed through the wall. - One, approximate ten inch long by one half inch wide open unsealed penetration. - One, approximate ten inch long by three inch wide open unsealed penetration. - One, three inch long by two inch wide penetration filled with mineral wool that was not sealed with a fire rated material. - One, eight inch long by three inch wide penetration filled with mineral wool that was not sealed with a fire rated material. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2000 NFPA 101: 18.1.1.4, 18.1.1.4.1, 18.1.1.4.2, 8.2, 8.2.1(1)	K 012	Maintenance of designee. 3)The results of audit and corrections made will be presented and reviewed at the facility Quality Assurance Committee meeting on an ongoing basis The Director of Maintenance will be responsible for the implementation and evaluation of this corrective action.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD is not met as evidenced by: Based on observation and interview during a Life Safety Code survey completed on 4/25/16, a smoke barrier wall was not designed to have at least a one hour fire resistance rating. This affected one (Canal View) of five resident units. The findings are: 1. Observation above the corridor's ceiling tiles on the Canal View unit on 4/20/16 at approximately 12:22 PM revealed an approximate two inch circular conduit that was installed through the smoke barrier wall, above	K 025	The following was accomplished for the deficiency cited: The two inch circular conduit that was installed through the smoke barrier wall, above the smoke barrier doors, near Resident Room #43 was partially filled with mineral wool was sealed with a fire rated material. The following corrective actions have been accomplished to identify other areas that have potential to be affected by this same deficiency: 1)Visual inspection of all smoke barrier walls within the facility was completed by the Director of Maintenance or designee. 2)Any further penetrations identified during the Director's inspection will be immediately corrected. The following systemic changes have been implemented to assure continued compliance with the regulation: 1)A monthly inspection audit of all smoke barrier walls within the facility will be	06/17/2016

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K 025	Continued From page 2 the smoke barrier doors, near Resident Room #43 was partially filled with mineral wool that was not sealed with a fire rated material. Interview with the Housekeeping Director at the time of the observation revealed he was not sure why the conduit was partially filled with mineral wool that was not sealed with a fire rated material. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2000 NFPA 101: 18.3.7, 18.3.7.3, 8.3, 8.3.2	K 025	conducted by the Director of Maintenance or designee. 2)Any and all identified smoke barrier penetrations will be immediately and properly sealed with a fire rated material by the Director of Maintenance of designee. 3)The results of audit and corrections made will be presented and reviewed at the facility Quality Assurance Committee meeting on an ongoing basis The Director of Maintenance will be responsible for the implementation and evaluation of this corrective action.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview during a Life Safety Code survey completed on 4/25/16, exit egress doors that were equipped with electromagnetic delayed-egress locking mechanisms did not have signage stating how the door functioned. This affected three (Canal View, Garden View, and Orchard View) of five resident units and one of one Villages main dining room. The findings are: 1. Observation on the Canal View Unit on 4/22/16 at approximately 11:53 AM revealed the exit egress door located near Resident Room #37 was equipped with an electromagnetic delayed-egress locking mechanism and the door did not have signage stating how the door functioned.	K 038	The following was accomplished for the deficiency cited: 1) The exit egress door located near Resident Room #37 was equipped with an electromagnetic delayed-egress locking mechanism and the door had the appropriate sign indicating door function placed on it. 2)The egress door the Orchard View Unit near Resident Room #22 was equipped with an electromagnetic delayed-egress locking mechanism and the door had a sign stating how the door functioned was placed on the door. 3)Garden View Unit, the exit egress door located near Resident Room #37 was equipped with an electromagnetic delayed-egress locking mechanism and the door had a sign stating how the door functioned was placed on the door. 4)The exit egress door located in the Villages main dining room was equipped with an electromagnetic delayed-egress locking mechanism and the door had a sign stating how the door functioned was placed on the door.	06/17/2016

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K 038	Continued From page 3 An interview with the Maintenance Director at the time of this observation revealed delayed-egress locking mechanisms had been installed on exit egress doors in the Canal View unit, Garden View unit, Orchard View unit, and the Villages main dining room approximately eight months ago. Further interview with the Maintenance Director at the time of this observation revealed he was not aware that doors equipped with an electromagnetic delayed- egress locking mechanism had to have signage on them that stated how the door functioned. 2. Observation on the Orchard View Unit on 4/22/16 at approximately 11:56 AM revealed the exit egress door located near Resident Room #22 was equipped with an electromagnetic delayed-egress locking mechanism and the door did not have signage stating how the door functioned. 3. Observation on the Garden View Unit on 4/22/16 at approximately 11:58 AM revealed the exit egress door located near Resident Room #37 was equipped with an electromagnetic delayed-egress locking mechanism and the door did not have signage stating how the door functioned. 4. Observation on 4/22/16 at approximately 12:01 PM revealed the exit egress door located in the Villages main dining room was equipped with an electromagnetic delayed-egress locking mechanism and the door did not have signage stating how the door functioned. Per National Fire Protection Association (NFPA) 101 Life Safety Code 7.2.1.6.1(d) Delayed-Egress locks: On the door adjacent to the	K 038	The following corrective actions have been implemented to identify other areas that may have similar potential to be affected by this practice. 1) All other electromagnetic delayed-egress doors within the entire facility were also addressed with the correct signage. The following systemic changes have been implemented to assure continued compliance with this regulation. 1)A monthly audit will be conducted on all electromagnetic delayed-egress doors within the facility which addresses proper signage and physical function of the doors. 2) Results of this audit will be present at the facility Quality Assurance Meeting. The Director of Maintenance will be responsible for implementation and evaluation of this corrective action.	

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K 038	Continued From page 4 release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2000 NFPA 101: 18.2.1, 7.1, 7.2, 7.2.1, 7.2.1.6, 7.2.1.6.1(d)	K 038		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: THIS IS A REPEAT DEFICIENCY OF THE LIFE SAFETY CODE SURVEY COMPLETED ON 2/6/15. Based on interview and record review during a Life Safety Code survey completed on 4/25/16, the building's fire alarm system was not properly maintained. Issues included audio/visual signal devices, visual only signal devices, and electromagnetic releasing devices that were not tested on an annual basis. This affected three (Canal View, Garden View, and Orchard View) of five resident units. The findings are: 1. A review of a Fire Drill Evaluation Forms	K 052	A)The following was accomplished for the deficiency cited: 1)Director of Maintenance initiate an internal fire drills at which time all audio/visual signal devices, visual only signal devices, and electromagnetic releasing devices were tested. B)The following corrective actions have been implemented to identify other areas that may have similar potential to be affected. 1) Entire facility had potential to be affected by this deficient practice C)The following systemic changes have been implemented to assure continued compliance with this regulation. 1)In-servicing of Maintenance staff regarding fire drill policy to include A/V and VSIG devices during all fire drills which occur on day shift. 2)Fire Drill evaluation form will indicate functioning of A/V as well as VSIG devices during drills. 3)Contracted testing of all AV/and VSIG devices within the facility has been added and will occur on a semi-annual basis. 4)The Maintenance Director will conduct audit of A/V and VSIG devices during each fire drill and report results to the facility Quality Assurance meeting.	06/17/2016

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K 052	Continued From page 5 dated 1/5/15 through 12/21/15 on 4/21/16 revealed they contained no documentation that audio/visual signal devices, visual only signal devices, and electromagnetic releasing devices had been tested. Review of Fire Alarm Inspection Reports dated 2/24/15 and 8/7/15 on 4/25/16 revealed they contained no documentation that audio/visual signal devices, visual only signal devices, and electromagnetic releasing devices had been tested. Interview with the Maintenance Director on 4/25/16 at approximately 9:01 AM revealed he believed that the outside contractor inspected and tested the building's automatic fire alarm system, had inspected and tested the audio/visual signal devices, visual only signal devices, and electromagnetic releasing devices on 2/24/15 and 8/7/15 when they were inspecting and testing the building's automatic fire alarm system. Per the 1999 edition of National Fire Protection Association (NFPA) 72 National Fire Alarm Code: Table 7-3.2 Testing Frequencies; Alarm notification devices, visible devices, and electromechanical releasing device shall be tested annually. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2000 NFPA 101: 18.3.4, 18.3.4.1, 9.6, 9.6.1.4 1999 NFPA 72: 7-3.2, Table 7-3.2 Testing Frequencies	K 052	The Maintenance Director will be responsible for the overall monitoring, evaluation and implementation of this plan.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	A)The following was accomplished for the deficiency cited: 1)Two blankets and two comforters that were stored directly below and less than 18 inches from a sprinkler head located in the Linen Storage Closet near Resident Room #27 were removed immediately. Also, On the Orchard View unit, four blankets were	06/17/2016

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K 062	Continued From page 6 THIS IS A REPEAT DEFICIENCY FROM THE LIFE SAFETY CODE SURVEY COMPLETED ON 2/6/15. Based on observation, interview, and record review during a Life Safety Code survey completed on 4/25/16, items were stored directly below and less than 18 inches from sprinkler heads, quarterly inspecting and testing was not conducted on the building's automatic sprinkler system, and damaged sprinkler heads had not been replaced. This affected, three (Canal View, Garden View, Orchard View) of five resident units. The findings are: 1. Observation on the Orchard View unit on 4/19/16 at approximately 10:55 AM revealed two blankets and two comforters were stored directly below and less than 18 inches from a sprinkler head located in the Linen Storage Closet near Resident Room #27. An interview with the Director of Housekeeping during the time of this observation revealed the facility's staff knew they were not to store items so close to the sprinkler heads. Further observation on the Orchard View unit on 4/21/16 at approximately 12:17 PM revealed four blankets were stored directly below and less than 18 inches from a sprinkler head located in the Linen Storage Closet near Resident Room #27. 2. Record review of sprinkler inspection reports on 4/22/16 revealed the facility had no documentation that the building's automatic sprinkler system had been inspected during the Second quarter (April, May, June) of 2015, the Fourth quarter (October, November, December) of 2015, and the First quarter (January,	K 062	stored directly below and less than 18 inches from a sprinkler head located in the Linen Storage Closet near Resident Room #27 were removed immediately. 2)An outside company has been hired to inspect the automatic sprinkler system including damaged ad corroded sprinkler heads. B) The following corrective actions have been implemented to identify other areas that may have potential to be affected by this same practice 1) All facility sprinkler heads have been inspected by maintenance staff to ensure proper clearance from any obstruction. 2) All facility sprinkler heads have been inspected by the Maintenance Director to ensure they are free from corrosion and damage. C) The following systemic changes have been implemented to ensure continued compliance with the regulation. 1)We have hired an outside company to inspect and replace corroded and damaged sprinkler heads. 2)The Maintenance Director or designee will audit all sprinkler heads within the facility monthly to ensure proper clearance. The audit results will be reported to the facility Quality Assurance meeting 3) The Maintenance Director will provide direct oversight and give final approval for work completed by any contractors prior to contractor departure from facility. 4)The Maintenance Director or designee will provide in-service training for all staff members regarding NFPA101 Life Safety Standard requiring automatic sprinklers being continuously maintained in reliable operating condition and free from obstructions.	

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K 062	Continued From page 7 February, March) of 2016. Further review of the sprinkler inspection reports on 4/22/16 revealed there were damaged sprinkler heads on the Canal View unit, in Resident Room #38 and in the Tub Room. Interview with the Maintenance Director on 4/22/16 at approximately 9:51 AM revealed the building's automatic sprinkler system was not inspected and tested in the Second and Fourth quarters of 2015 and the First quarter of 2016. Further interview with the Maintenance Director at this time revealed none of the damaged sprinkler heads had been replaced. 3. Observation on the Canal View unit on 4/25/16 at approximately 8:42 AM revealed the deflector on a sprinkler head located in Resident Room #38 was bent. 4. Observation in the Canal View unit on 4/25/16 at approximately 8:43 AM revealed the deflector on a sprinkler head located in the shower area of the Tub Room was bent. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2000 NFPA 101: 9.7.5, 18.7.6, 4.6.12, 4.6.12.1 1999 NFPA 13: 5-6, 5-6.6 1998 NFPA 25: 2-1, Table 2-1, 2-2, 2-2.1.1	K 062	5) Results of these audits/inspections will be reported to the Quality Assurance Team. The Maintenance Director will be responsible for the monitoring, evaluation and implementation of this plan.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observations during a Life Safety Code survey completed on 4/25/16, a portable fire extinguisher was obstructed. This affected	K 064	A)The following was accomplished for the deficiency cited: 1)The five wet floor signs stored against and obstructing the ABC fire extinguisher near the door, the two wet floor signs obstructing the ABC portable extinguisher near the servery were promptly removed to appropriate storage area. In addition, the three foot tall dietary cart stored against and obstructing the ABC fire extinguisher near the server door was also moved to appropriate location	06/17/2016

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K 064	Continued From page 8 one of one portable fire extinguisher located near the Servery in the Villages dining room. The findings are: 1. Observation in the Villages dining room on 4/19/16 at approximately 9:50 AM revealed five wet floor signs were stored against and obstructing the ABC portable fire extinguisher located near the door to the Servery. Additional observation in the Villages dining room on 4/19/16 at approximately 9:50 AM revealed an approximately three foot tall by three foot long by two foot wide dietary cart was stored directly against and obstructing the ABC portable fire extinguisher located near the door to the Servery. Further observation in the Villages dining room on 4/22/16 at approximately 8:09 AM revealed two wet floor signs were stored against and obstructing the ABC portable fire extinguisher located near the door to the Servery 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2000 NFPA 101: 18.3.5.6, 9.7.4.1 1998 NFPA 10: 4-3, 4-3.2(b)	K 064	B)The following corrective actions have been implemented to identify other areas in the facility that have potential to be affected by this practice: 1)All units within the facility were audited by the Director of Maintenance or designee will make rounds to ensure all fire extinguishers were not obstructed. C)The following systemic changes have been implemented to ensure continued compliance with the regulation: 1)All facility staff were in-serviced on unobstructed fire extinguisher access. 2)A monthly audit will be conducted assessing all fire extinguishers within the facility to ensure the access is not obstructed. 3) The results of the audit will be presented and reviewed at the facility Quality Assurance meeting to ensure continued compliance with the regulation The Director of Maintenance will be responsible for implementation and evaluation of this corrective action.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	K 076	A)The following was accomplished for the deficiency cited: 1)17- Cardboard box was removed from the oxygen storage room located between Resident Rooms #33 and #34. B)The following corrective actions have been implemented to identify other areas that may have similar potential to be affected. 1)The entire facility was audited for proper oxygen use as well as storage of oxygen cylinders	06/17/2016

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K 076	Continued From page 9 This STANDARD is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE LIFE SAFETY CODE SURVEY COMPLETED ON 2/6/15. Based on observation and interview during a Life Safety Code survey completed on 4/25/16, oxygen cylinders were stored within five feet of combustibles and an oxygen cylinder was not properly restrained. This affected one (Canal View) of five resident units. The findings are: 1. Observation on Canal View unit on 4/19/16 at approximately 11:11 AM revealed 17- E sized oxygen cylinders were stored within two feet of a cardboard box containing medical supplies in the Oxygen Storage room located between Resident Rooms #33 and #34. 2. Observation on the Canal View Unit on 4/21/16 at approximately 11:51 AM revealed one E sized oxygen cylinder in a nylon carrying case was stored free standing and unsecured in Resident Room #30. Further observation at this time revealed the oxygen cylinder was stored behind a chair located in the room. Interviews with both the Maintenance Director and the Housekeeping Director at the time of this observation revealed they were not aware the oxygen cylinder was in the room. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2000 NFPA: 18.3.2.4 1999 NFPA 99: 8-3.1.11.2, 8-3.1.11.2(c)2, 8-3.1.11.2(h), 4-3.5.2.1(b)27	K 076	C)The following systemic changes have been implemented to assure continued compliance with this regulation. 1)Annual in services on oxygen storage and use will be done with staff annual in-servicing requirements 2) a monthly Audit will be conducted by the Maintenance Director or designee during rounds and report them to the Quality Assurance team for review and determination of ongoing compliance The Director of Maintenance will be responsible for implementation and evaluation of this corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING 03 - 2006 BUILDING B. WING _____	04/25/2016

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K 144 K 144 SS=E	Continued From page 10 NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on interview and record review during a Life Safety Code survey completed on 4/25/16, the emergency generator was not tested under load for at least 30 minutes on a monthly basis. This affected, three (Canal View, Garden View, Orchard View) of five resident units. The findings are: 1. Review of the emergency generator monthly load test logs on 4/21/16 and 4/22/16 for the emergency generator that provided emergency power for the Canal View, Garden View, and Orchard View units revealed the following: - The emergency generator was not run under load during February and September of 2015. - The emergency generator was run under load for less than 30 minutes during October of 2015. Interview with the Maintenance Director on 4/22/16 at approximately 8:23 AM revealed that when he first started working at the facility he thought the emergency generator had to be run for 15 minutes under load on a monthly basis. Further interview with the Maintenance Director at this time revealed he started working at the facility during March of 2015. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2000 NFPA: 18.7.6, 4.6.12, 4.6.12.1 2000 NFPA 110: 6-4, 6-4.2	K 144 K 144	A)The following was accomplished for the deficiency cited: 1)The emergency generator was tested under load for at least 30 minutes. This was changed to 30 minutes according to regulation starting in December 2015. B)The following corrective actions have been implemented to identify other areas that may have similar potential to be affected. 1) The Maintenance Director will run the emergency generator under load for at least 30 minutes on a monthly basis. The generators also run a weekly test. C)The following systemic changes have been implemented to assure continued compliance with this regulation. Generators will run under load for at least 30 minutes per month. logs are updated weekly and report to the Quality Assurance committee. The Director of Maintenance will be responsible for implementation and evaluation of this corrective action.	06/17/2016

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K 147 K 147 SS=E	Continued From page 11 NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE LIFE SAFETY CODE SURVEY COMPLETED ON 2/6/15. Based on observation and interview during a Life Safety Code survey completed on 4/25/16, extension cords were being used to supply a permanent supply of power to various electrical appliances, electrical junction boxes were missing covers, duplex electrical outlets were missing covers, and a power strip that was not approved to be used in a resident room was being used to supply power to electrical appliances in a resident room. This affected, three (Canal View, Garden View, Orchard View) of five resident units. The findings are: 1. Observation on the Garden View unit on 4/19/16 at approximately 10:49 AM revealed a radio was plugged into an extension cord that was plugged into a duplex outlet located in the Television Room. 2. Observation on the Canal View unit on 4/19/16 at approximately 11:18 AM revealed three electrical junction boxes locate in the penthouse were missing their covers. Further observation at this time revealed red wiring was sticking out of the boxes. Interview with the Maintenance Director at the	K 147 K 147	A)The following was accomplished for the deficiency cited: 1)Remove the extension cord from the Television Room on the Garden View Unit. 2)Installed covers on the three electrical junction boxes located in the Penthouse and fixed the red wire that was sticking out of the box. 3)Removed the power strip that was located in Resident Room #43. 4)Replaced the cover for the junction box on Orchard View between Resident Rooms #29 and #43. 5)Replaced the junction box cover located near the smoke barrier doors on the activities room side of the doors. 6)Replaced the cover on a duplex electrical outlet in Resident Room #412. 7)Removed the extension cord that was plugged into an electrical outlet in Resident Room#19. B)The following corrective actions have been implemented to identify other areas that may have similar potential to be affected. 1) The maintenance director will follow outside contractors and inspect their work during and after projects. The Maintenance Director and the Environmental Directors will also do daily visual audit. 2) The Director of Maintenance completed an entire facility wide, room by room inspection to ensure no extension cords, electrical boxes appropriately covered, power strips were not in use. C)The following systemic changes have been implemented to assure continued compliance with this regulation. 1) The Director of Maintenance will conduct room by room audit monthly to	06/17/2016

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K 147	Continued From page 12 time of these observations revealed the red wiring was for the building's fire alarm system and an outside contractor conducted all of the maintenance and testing of the building's fire alarm system. 3. Observation on the Canal View unit on 4/20/16 at approximately 12:12 PM revealed a digital versatile disc player, a phone, and a lamp were plugged into a power strip that was plugged into a duplex electrical outlet in Resident Room #43. Further observation at this time revealed the power strip was not rated to be used in a resident room. 4. Observation above the corridor ceiling tiles on the Canal View unit on 4/20/16 at approximately 12:24 PM revealed an electrical junction box located between Resident Rooms #29 and #43 was missing its cover. 5. Observation above the corridor ceiling tiles on the Orchard View unit on 4/20/16 at approximately 12:30 PM revealed an electrical junction box located near the smoke barrier doors was missing its cover. Further observation at this time revealed the junction box was located on the activities room side of the doors. 6. Observation on the Canal View unit on 4/21/16 at approximately 12:11 PM revealed a duplex electrical outlet in Resident Room #412 was missing its cover. 7. Observation on the Orchard View unit on 4/21/16 at approximately 12:32 PM revealed two illuminated holiday decorations were plugged into an extension cord that was plugged into a duplex electrical outlet in Resident Room #19. 10 NYCRR 415.29(a)(2), 711.2(a)(1)	K 147	identify no extension cords, only appropriate power strips are in use, and all electrical boxes are appropriately covered. 2)The results of this audit will be reported and reviewed monthly at the facility Quality Assurance Committee for a minimum of three months or until team determines facility is in ongoing compliance The Director of Maintenance will be responsible for implementation and evaluation of this corrective action	

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K 147	Continued From page 13 2000 NFPA 101: 18.5, 18.5.1, 18.5.1.1, 9.1, 9.1.2 1999 NFPA 70: Article 110, 110-3(a)1, 110-3(a)8, Article 305, 305-3(b) Article 370, 370-25, 370-72(c), Article 400, 400-8, 1	K 147		

EXHIBIT 26

APPROVED 9/18/17 710111

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2017
FORM APPROVED
OMB NO. 0938-0391

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F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00196646) completed on 6/22/17, the facility did not ensure that the resident's environment remained free of accident hazards as is possible and each resident receive adequate supervision and assistance devices to prevent accidents. Two (Residents #1, 2) of three residents reviewed for resident to resident	F 323	The following corrective action has been implemented for the deficiency cited: A) The Director of Nursing reviewed the medical record to include a pharmacy review of the meds with the Medical Provider for Residents #1 and #2. Resident #1 was started on Exelon Patch QD. No changes have been made for Resident #2 at this time due to resolved behaviors. Resident #1 was placed on locked Memory Care unit, Resident #2 remained on the Villages unit. The units are separate from each other and there is no chance of them coming in contact with each other. 1:1 was removed from Plan of Care for resident #2 since his behaviors have resolved. B) A 100% audit of all incident reports involving cognitively impaired residents with aggressive behaviors since June 1, 2017 will be reviewed for interventions. Those interventions will be validated that they are on the Kardex and care plan, as appropriate, for aides, and listed on the 24h report for 7 days so all nurses are aware of changes. C) All nursing staff will be re-educated about the importance of following the care plan and Kardex. A post test regarding new A & I interventions and communication of those changes will be given to all CNAs for completion. D)A supervisors meeting will be held by the Director of Nurses/designee as it relates to incident interventions, accountability, communication and assigning breaks. All full time and part time CNAs will be re-	08/21/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	09/18/2017

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F 323	Continued From page 1 altercations had issues. Specifically, one to one supervision when out of bed was not conducted per the care plan for a resident with a history of resident to resident altercations (involving Resident #2) (Resident #1). Resident #1 wandered undetected to another unit, strucking Resident #2 three times in the chest before staff intervened. The findings are: 1. Resident #1 has diagnoses of dementia with behavioral disturbances. Review of the quarterly Minimum Data Set (MDS - a resident assessment tool) dated 4/19/17 revealed the resident had short and long term memory problems, was understood and usually understands; and is independent with ambulation. Resident #2 has diagnoses of dementia and epilepsy. Review of the quarterly MDS dated 5/5/17 revealed the resident is severely cognitively impaired and is independent with ambulation with a rolling walker. Review of Resident #1's Care Plan dated 3/4/17 revealed the resident was not to come in contact with Resident #2. Resident #1 will be monitored one to one at all times when out of bed. Review of an undated Certified Nurse Aide (CNA) Care Plan revealed Resident #1's triggers for physical aggression include disruptive residents and people who are a different race than him. Resident #2 is of a different race than Resident #1. Review of an undated CNA Care Plan revealed that Resident #2 is to be kept away from Resident #1 at all times. Under behaviors	F 323	educated on the proper way to approach/interact with residents who display aggressive behaviors. The Unit Managers and Nursing supervisors will audit weekly that incident interventions are in place at time of their audit. Those audits will be reviewed with the Director of Nursing/designee. The Unit Managers & Unit Supervisors will be responsible for this plan of correction. The following systemic changes will be implemented to ensure continued compliance with the regulation: A) The Director of Nursing/designee will conduct a random audit of one new incident report per week, per unit on interventions and A&I's with behaviors. This will be accomplished through observation and query of both the licensed nurse and the certified aide to validate that the interventions listed are in place. B.) All Audit findings will be analyzed and presented at the monthly QA meeting for 3 months, for additional comments and/or recommendations. The Director Of Nursing is responsible for overall compliance with this plan of correction.	

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F 323	Continued From page 2 revealed Resident #2's triggers for physical aggression are other residents displaying anger toward him. Review of an Incident/Accident Report dated 4/3/17 at approximately 1:00 AM revealed there was an altercation between Resident #1 and Resident #2. Staff written statements revealed the Garden Unit nurse was putting away a medication cart in the Medication Room and the two Certified Nurse Aides (CNAs) were making rounds on another unit when Resident #1 wandered off the Garden Unit undetected to the Canal Unit and struck Resident #2 approximately three times in the chest. No injury was noted. Interview with CNA #1 (that worked the Garden Unit 11:00 PM to 7:00 AM on 4/3/17) on 6/20/17 at approximately 10:00 AM revealed the last time she observed Resident #2, he was sitting on the Garden Unit's couch. CNA #1 stated that both residents were independent with ambulation and could move freely between units. CNA #1 stated she was helping another CNA with two assists on the Orchard Unit because there were only two CNA's working and could not provide one to one with Resident #1. CNA #1 stated that the Supervisor is supposed to watch the hall when the CNA's are not there. CNA #1 could not recall if she told the Unit Nurse they were leaving the unit. Interview with the Registered Nurse (RN) #1 on 6/20/17 at approximately 10:30 AM revealed RN #1 and the Unit Nurse were in the Nurse's Station when they heard Resident #1 yelling and using racial slurs towards Resident #2 on the Canal Unit. RN #1 saw Resident #1 strike Resident #2 three times in the chest. RN #1 stated that if there were only two CNA's that	F 323		

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F 323	Continued From page 3 night they probably were rounding the halls together and should have told the Unit Nurse on Garden Unit they were leaving the unit. RN #1 stated that the Unit Nurse should have told the Supervisor that she was off the unit. RN #1 did not believe anyone was watching the Garden or Canal Units hall at the time of the incident and stated that there should have been better communication between the staff to let each other know what they were doing so the residents could be monitored. Interview with the Director of Nursing (DON) on 6/21/17 at approximately 1:00 PM revealed she expects that if a resident is a one to one, staff should watch that resident; if the CNA's are off the unit they should tell their nurse. If the Unit Nurse cannot watch the resident or is off the floor, then the Unit Nurse should tell the Supervisor. The DON stated that it is the nurse's responsibility to watch the unit. Review of the facility policy and procedure entitled Interdisciplinary Care Plan dated 2/2015 revealed that all licensed nurses are responsible to ensure that the Care Plan is carried out in the resident's daily routine.	F 323		
F 514 SS=D	415.12(h)(1) 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 514	The following corrective actions have been implemented for the deficiency cited: A)The closed record for Resident #3 was reviewed by the Director of Nursing to ensure there were no other periods of time when fluids were not documented/provided. B)All Nursing Staff will be re-educated on all physician ordered additional fluid pass and the documentation of such fluid per the	08/21/2017

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F 514	Continued From page 4 (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00198386) completed on 6/22/17, the facility did not maintain clinical records on each resident in accordance with accepted professional standard and practices that are readily accessible. One (Resident #3) of three residents reviewed for Medical Record documentation had issues. Specifically, fluid intake with medication pass on the Medication Administration Record (MAR) and daily fluid intake on the 24-Hour Reports were not documented by staff for the month of March 2017.	F 514	facility policy. C)The additional fluids per physician order with med pass will be listed on the MAR for documentation of acceptance or refusal for each resident. The licensed nurses will be re-educated and a post test given as it relates to the material presented. The Unit Managers will audit the MAR on a weekly basis for eight(8)weeks to ensure that the physician ordered documentation is being obtained for fluids with meds. Any resident receiving an MD order for fluid encouragement will be reflected on MD order and noted on 24 hour report. The Unit Managers will be responsible for compliance of this plan of correction. The following systemic changes have been implemented to ensure continued compliance with the regulation: A)The Unit Managers will audit MAR for compliance weekly for 8 weeks. The Unit Manager will review the weekly audits with the Director of Nursing/designee weekly. In the event there is a less than 90% compliance in any one month, the audit frequency will be increased. The Director of Nursing/designee will trend the audit results and present at the monthly QA for 3 months for additional comments and/or recommendations. The Director Of Nursing will monitor for overall compliance with this plan of correction.	

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F 514	Continued From page 5 The finding is: 1. Resident #3 has diagnoses of dementia and cerebrovascular accident (stroke). Review of the admission Minimum Data Set (MDS - a resident assessment tool) revealed that the resident is severely cognitively impaired. Review of a Physician's Order dated 3/9/17 revealed an order to encourage 240 milliliters (eight ounces) of fluids every shift for hydration. Review of the March 2017 MAR revealed no nurse's initials from 3/9/17 through 3/31/17 documenting that fluids were given to the resident. Review of the March 2017 fluid intake report revealed only one entry by a nurse that fluids were provided with a medication pass. Interview with the Certified Nurse Aide (CNA) #2 on 6/22/17 at approximately 8:45 AM revealed that the CNA's document the amount the resident takes for fluids. Interview with Licensed Practical Nurse (LPN) #1 on 6/22/17 at approximately 9:00 AM revealed that she would usually get the resident to drink two cups (approximately 480 milliliters or 16 ounces) of punch per medication pass because the resident preferred it. LPN #1 stated she would document it but sometimes forgot to put the amount the resident drank during medication passes. LPN #1 added that if there is an order to encourage fluids everyone tries to get the resident to drink at least 240 milliliters of fluids per shift. Interview with LPN #2 on 6/22/17 at	F 514		

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F 514	Continued From page 6 approximately 9:10 AM revealed that sometimes the nurses will write how much a resident drank during medication passes on the 24-hour reports. Review of the 24-hour reports revealed no documentation the resident received fluids during medication passes. Interview with Registered Nurse (RN) #2 on 6/22/17 at approximately 10:00 AM revealed that the nurses should be documenting the resident's fluid intake in the computer. RN #2 stated that every nurse should be encouraging the resident to drink fluids and that amount should be documented. Interview with the Director of Nursing on 6/22/17 at approximately 11:00 AM revealed she expects staff to document the resident's intakes. Review of an undated facility policy titled Resident Hydration and Prevention of Dehydration that staff will document fluid intake per shift via the computer in the task section. 415.22(a)(2)	F 514		

EXHIBIT 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	07/12/2017

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

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F 226 SS=B	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews conducted during the Recertification Survey, it	F 226 Accepted 8/8/17 MG	The following corrective action has been implemented for the deficiency cited: 1)The three employees were immediately screened on the nurse aide registry. 2)A 100% audit was completed of all active employees and agency staff to ensure the nurse aide screen was present. Any area identified through the audit was corrected immediately. 3)The Administrative Assistant was re-educated about completing the nurse aide screening. The new employee check off sheet was modified to include the nurse aide registry screen and the screen will be attached to the new employee information by the Administrative Assistant. A double check system will be utilized and the presence of the screen will be verified during facility general orientation. The following action will be completed to assure all new hires and agency staff have been screened via the nurse aide registry: 1)A monthly audit will be completed by the Administrative Assistant for all active employees that the screen is present. The Administrator will complete a random review of 5 employees from each department to validate the screen form is present. The results of the monthly audit will be reviewed at the QA meeting monthly for additional comments and/or recommendations to the process. The monthly audit will be completed by the Administrative Assistant, and if 100% compliance is maintained for 3 months, the audit will be completed quarterly for three quarters. The Administrative Assistant will be responsible for the prescribed plan of	08/17/2017

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

Electronically Signed | 07/27/2017

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F 226	Continued From page 1 was determined that for three Certified Nursing Assistant (CNA), Housekeeper, and an Activities Aide of seven employee files reviewed for the Nurse Aide Registry Abuse Screen the facility did not conduct a review prior to the onset of employment. Issues included a lack of documentation that employees were screened through the Nurse Aide Registry. This is evidenced by the following: On 7/11/17 from 11:25 a.m. to 11:55 a.m., the Administrative Assistant provided the surveyor with records of recently hired employees. The records showed a CNA was hired on 6/27/17, a Housekeeper was hired on 3/19/17, and an Activities Aide was hired on 6/5/17. There was no documentation provided by the facility to show that these three employees were screened for abuse through the New York State Nurse Aide Registry. When interviewed at that time, the Administrative Assistant said all new employees are screened through the Nurse Aide Registry. The Administrative Assistant said she was sure the screenings were done, but could not find the documentation. The facility policy for Abuse Prohibition Protocol directed that the facility screens potential employees, contractors, and volunteers who have resident contact against the Nursing Home Nurse Aid Registry. [10 NYCRR 415.4(b)(1)(i-iii)]	F 226	correction and monitored by the Administrator for compliance.	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and	F 242 Accepted 8/8/17 mo	The following corrective action has been implemented for the deficiency cited: 1. The resident choice to be bathed before breakfast has been honored. The care plan has been changed to reflect this preference. 2. A 100% audit of all current residents was completed to determine resident	08/17/2017

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F 242	Continued From page 2 other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #67) of three residents reviewed for choices, the facility did not allow a resident to make choices about schedules consistent with her interests. Specifically, the resident was not able to choose when to receive a shower. This is evidenced by the following: Resident #67 was admitted to the facility on 5/3/16 with diagnoses including depression and anxiety. The Minimum Data Set Assessment, dated 4/19/17, revealed that the resident is cognitively intact and that it is very important to choose between a tub bath, a shower, a bed bath or a sponge bath. When interviewed on 7/6/17 at 1:00 p.m., the resident said she had not received a shower in two weeks. The resident said she would like a shower before breakfast. She said staff will not start showers until they finish with other people so you have to wait. The resident said she does not like to wait. She said when staff ask her to	F 242	choice for bathing. Any discrepancies noted were corrected and the shower schedule and care plan were changed to reflect a change in preference. 3. All full and part-time aides and licensed nurses were re-educated about honoring resident preferences for bathing and resident rights. A post-test was developed and distributed. The master bath schedule was modified to reflect any changes. As part of general orientation for new employees, resident rights to include resident preferences, have been included in the lesson plan as well as the post-test. A monthly analysis will be completed by the Activity Director and reviewed with the Director of Nurses/designee for new resident bathing preferences. All bathing preferences will be re-visited quarterly and with any significant change in condition. If the resident does not have the cognitive ability to decide when they want their bath, the family will be contacted by SS for past practice. The SS team will audit three residents per unit per month to verify that resident is receiving their bath according to their documented preference. The results of those audits will be reviewed with the Director of Nurses/designee. The Activity Director will be responsible for this corrective action and the DON/designee will monitor for compliance. 4. The monthly analysis will be discussed by the Activity Director at the monthly QA meeting for additional comments and recommendations. This analysis will be completed monthly and trended for compliance by the Activity Director. The Activity Director will be responsible for this plan of correction. The monthly audit and analysis will be completed monthly for	

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F 242	Continued From page 3 shower after breakfast she will refuse because she is dressed for the day and does not want to get undressed. When interviewed on 7/7/17 at 11:15 a.m., the three Certified Nursing Assistants (CNA) assigned to the unit said that the staff choose the bath day and time. They said that baths are given after breakfast due to the number of residents they provide care for. They said sometimes we give good bed baths because we cannot fit in a shower. They said the resident is assigned a shower on Wednesday. They said they are not allowed to give showers until after breakfast even if the resident wants it because they do not have enough staff to do showers and get everyone into the dining room for the meal. They said this was directed by nursing administration. The CNAs said that they know the resident wants her shower before breakfast. They said they will offer her a shower after breakfast, but by then the resident is dressed and refuses to get undressed to shower. When interviewed on 7/10/17 at 4:07 p.m., the Director of Nursing said that she expects residents to receive their showers when they want them. She said the staff misunderstood her when she told them to have residents in the dining room and to assist with the meal. [10 NYCRR 415.5(b)(3)]	F 242	three months and reviewed at that time by the QA committee for any change in frequewncy or duration.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in	F 282	The following corrective action has been implemented for the deficiency cited: 1)Resident #42 was reassessed for continuation of bilateral heel booties, glasses, chair alarm and chair cushion. 2)A 100% audit of care plans was conducted to identify those residents requiring heel booties, glasses, alarms and chair cushions. Any indication of these	08/17/2017

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F 282	Continued From page 4 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #42) of two residents reviewed for pressure ulcers, the facility did not provide services in accordance with the resident's written plan of care. Issues included the lack of glasses, pressure relieving chair cushion, chair alarm and heel booties. This is evidenced by the following: Resident #42 has diagnoses including renal failure, osteoarthritis, and dementia. The Minimum Data Set Assessment, dated 6/8/17, revealed that the resident's cognition is severely impaired, requires extensive assistance with all Activities of Daily Living, has highly impaired vision, uses corrective lenses, and has current pressure ulcers and a pressure reducing device for the chair. The current Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Card, directed heel booties to both feet, a pressure reducing gel cushion in the chair, ensure a pad type chair alarm is in place and functioning, and appropriate prescription eyeglasses are available to support the resident's participation in activities if needed. The CNA CareTracker Information Sheet, dated 7/10/17, revealed that the resident's chair alarm was in place. During an observation on 7/10/17 at 11:08 a.m.,	F 282	adaptive devices were listed and verified that the resident has these devices in place. 3)All nursing staff, including agency staff, were re-educated as to the importance of the use of the prescribed assistive devices. A post-test was given to reinforce the education of this subject matter. A list of current adaptive devices will be initiated and maintained on the unit roster and TAR so that the charge nurse can verify each shift that those devices are in place. The unit manager will audit the TAR on a weekly basis to determine if the plan of correction is being followed and present their findings to the Director of Nursing/designee. The following action will be completed to identify other resident's that have potential to be affected by this deficiency: 1)The weekly audit by the Unit Manager will continue weekly X eight weeks. If 100% compliance is maintained, during the monthly QA, a change in frequency can be discussed and modified as indicated. The Director of Nursing/designee will verify through weekly observation that all adaptive devices as indicated are in place and note on the audit tool. The Unit Managers/Nursing Supervisors are responsible for this plan of correction and supervised by the Director of Nursing/designee.	

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F 282	Continued From page 5 the resident was sitting in her wheelchair in the common area singing. The resident was wearing non-skid socks on her feet, which were pressed against the foot cushion. There was no chair alarm or cushion in the wheelchair, and the resident was not wearing glasses. Interviews conducted on 7/10/17 included the following: a. At 11:09 a.m., CNA #1 said the resident was care planned for booties on both feet, but did not have them on. She said CNA #2 assisted the resident with care that morning. b. At 11:19 a.m., CNA #2 said the resident is supposed to have a chair alarm on, but there was not one in the room. She said she did not know the resident was supposed to wear booties all day long. CNA #2 said that the resident should have a chair cushion and chair alarm in place. She said the resident should have been wearing her glasses. c. At 11:34 a.m., Licensed Practical Nurse (LPN) #1 said she is not familiar with the resident. When asked about the resident's glasses, cushion, booties and chair alarm, LPN #1 said that she would have to review the care plan. LPN #1 said that she just received a chair alarm for the resident. d. At 11:39 a.m., the Registered Nurse (RN) said she did not realize the booties should be worn all the time. The RN and the surveyor observed the resident's room at that time and were unable to find the resident's glasses, chair alarm, or chair cushion. e. At 11:48 a.m., LPN #2 said she was unsure, when asked about the resident's	F 282		

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F 282	Continued From page 6 booties, chair alarm, cushion, and glasses. After reviewing the CNA Care Card, LPN #2 said the resident should have all of them in place. The facility policy for Interdisciplinary Care Planning, dated February 2015, included all licensed nurses are responsible to ensure that the plan of care is being followed as written. [10 NYCRR 415.11(c)(3)(ii)]	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #109) of two residents reviewed for pressure sores, the facility did not ensure a resident having a pressure sore received the necessary treatment and services to promote healing and	F 314 Accepted 8/8/17 MO	The following corrective action has been implemented for the deficiency cited: 1)LPN #1 and LPN #2 were re-educated on treatment changes and protocol, and a proficiency was completed by the ADON. 2) All nurses performing treatments will be re-educated and proficiency completed. A post-test will be distributed. Any nurse not receiving a passing grade will be referred for remedial education and training. 3)All newly hired nurses will have a treatment proficiency completed during their orientation period. Treatment proficiencies will be completed semi-annually for current in-house nurses and maintained in their personnel file. The following actions have been completed to identify other residents in the facility that have potential to be affected by this deficiency: 1)The DON/ADON will randomly complete treatment observations on a weekly basis for one resident per unit on all units. An analysis will be completed and presented at the monthly QA meeting for additional comments and/or observations. The weekly audits will be completed weekly X eight weeks and if 100% compliance is maintained for four consecutive weeks, a request in change of frequency will be	08/17/2017

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F 314	Continued From page 7 prevent new sores from developing. Specifically, the treatment was not completed as ordered. This is evidenced by the following: Resident #109 has diagnoses including a Stage IV pressure ulcer (a wound which extends into the underlying bone and muscle) on the sacrum and right lower gluteal, paraplegia, diabetes, peripheral vascular disease, and gangrene to the toes on both feet. Physicians orders, dated 7/7/17, included to cleanse the sacral and right gluteal wound with wound cleanser, cover with Silver Alginate (highly absorbent dressing) into each wound base and any tunneling/undermining, and cover with a dry clean dressing daily and as needed. The July 2017 Treatment Administration Record directs staff to cleanse the sacrum with wound cleanser or normal saline, apply Silver Alginate to the wound, and lightly pack and cover with a dry, clean dressing daily and as needed. There is another entry, that directs to cleanse the right gluteal wound with wound cleanser or normal saline, apply and lightly pack Silver Alginate (rope) into wound and any undermining/tunneling, and cover with a clean dressing daily and as needed. During an observation of wound care on 7/10/17 at 10:01 a.m., two LPNs performed the resident's wound care. LPN #1 cleansed the inside of the sacral pressure ulcer using gauze which she had moistened with the wound cleanser. She then dried the inside of the pressure ulcer, using a dry gauze. A piece of Silver Alginate was cut the size of the pressure ulcer, and placed on the top of the wound, and covered with a larger gauze (ABD). The Silver Alginate was not lightly packed into the wound.	F 314	discussed at the monthly QA. The Unit Managers will be responsible for maintaining compliance of the prescribed plan of correction and monitored by the DON/ADON.	

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F 314	Continued From page 8 LPN #1 then soaked a gauze with wound cleanser, placed the gauze in the right gluteal wound, and used a Q-tip to move the gauze around inside the wound. The outer area of the wound was cleansed with another gauze soaked with wound cleanser. One piece of Silver Alginate was placed in the wound. The wound was not lightly packed, and Silver Alginate Rope was not used. A house barrier cream was applied around the peri-wound which was bright red in color, and an ABD pad was used to cover the wound. Interviews conducted on 7/10/17 included the following: a. At 10:29 a.m., LPN #1 said she was not aware the treatment book directs to use Silver Alginate Rope. She said there are no instructions to irrigate the wound with wound cleanser. The directions for the Wound Cleanser instructed to spray the wound or stream from approximately 3 inches away. LPN #1 said she did not have any education from this facility on how to perform wound care. b. At 10:35 a.m., the Registered Charge Nurse said placing Alginate into a wound is not considered lightly packing the wound. She said the wound should have been cleansed by spraying the wound cleanser into the wound. She said she is new to the facility, and is not sure how wound care is performed at the facility. Interviews conducted on 7/11/17 included the following: a. At 10:42 a.m., the Assistant Director of Nursing said that Alginate being placed into a	F 314		

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F 314	Continued From page 9 wound is not considered packing the wound as ordered by the physician. b. At 2:45 p.m., the Registered Charge Nurse and LPN #2, both said if a wound requires packing, then Alginate Rope should be used. [10 NYCRR 415.12(c)(1)]	F 314		

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K 223 SS=D	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observations and an interview conducted during the Life Safety Code Survey, it was determined that for one of one basement, the facility did not properly maintain doors that are designed to be self-closing and latching. Specifically, doors did not fully close and automatically latch. The findings are: Observations in the presence of the Director of Maintenance on 7/10/17 at approximately 10:55 a.m. revealed a door to the basement laundry room stopped approximately 3 inches short of closing and latching, and was equipped with a self-closing device. Additionally, a double door assembly to the soiled side of the laundry room would not automatically close and latch when released. One of the two doors was observed to catch on the door frame, which prevented it from fully closing. In an interview at that time, the Director of Maintenance stated that he needed	K 223 Accepted POC 8/11/17 JM	The following was accomplished for the deficiency cited: 1.) Door to the basement laundry room was adjusted by the Director of Maintenance to allow complete self closure of the door. 2.) The double door assembly on the soiled laundry room side was trimmed down by the Director of Maintenance to allow for automatic closure and latching of the door. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.)Inspection of all self closing and latching doors within the facility by the Director of Maintenance to ensure complete closure and latching of doors. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) A monthly audit to ensure each self closing and latching door within the facility closes and latches properly. 2.) Audit results will be reported & reviewed in the facility Quality Assurance meetings The Director of Maintenance will monitor for overall compliance of this plan of correction.	08/18/2017

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K 223	Continued From page 1 to trim down the door on the edge where it hits the frame. [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 101: 19.2.2.2.6, 7.2.1.8.2]	K 223		
K 374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Based on observations, an interview, and record reviews conducted during the Life Safety Code Survey, it was determined that for one of eight smoke barriers, the facility did not properly maintain smoke barrier doors. Specifically, a set of cross corridor smoke barrier doors did not fully close when released. The findings are: Observations in the presence of the Director of Maintenance during the initial tour of the facility on 7/10/17 at approximately 11:35 a.m. revealed the cross-corridor smoke barrier doors to the Canal View unit did not fully close when released. The doors were observed to swing and hit the latch, but then remained unlatched	K 374 Accepted per 8/11/17	The following was accomplished for the deficiency cited: 1.) The cross-corridor smoke barrier door to the Canal View unit was adjusted by the Director of Maintenance to allow complete closure of the door. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.)Inspection of all smoke barrier doors within the facility by the Director of Maintenance to ensure complete closure and latching of doors. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) A monthly audit to ensure each smoke barrier door within the facility closes and latches properly. 2.) Audit results will be reported & reviewed in the facility Quality Assurance meetings The Director of Maintenance will monitor for overall compliance of this plan of correction.	08/18/2017

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K 374	Continued From page 2 and partially open. The resulting gap at the meeting edge of the smoke barrier doors was approximately 2 inches. Further review of facility records on 7/10/17 at 1:57 p.m. revealed weekly smoke barrier door audits from 1/9/17 through 5/27/17 identified the fire doors to the "Villages" as not latching in the comments section. When interviewed regarding the audits, the Director of Maintenance stated that these were the same doors as the ones that did not properly close. [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 101: 19.3.7.8, 8.5.4.1]	K 374		
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observations, an interview, and record reviews conducted during the Life Safety Code Survey, it was determined that for four (Autumn View, Canal View, Garden View, and Orchard View) of four resident units, the facility did not properly maintain the heating, ventilation, and air conditioning system. Specifically, there was no record of testing of smoke and fire dampers. The findings are: 1. During a review of facility records on 7/10/17 at approximately 2:15 p.m. testing records of the fire alarm system did not include functional testing of smoke dampers. In an interview, the Director of Maintenance revealed he was not sure when the dampers were last	K 521 Accepted POC 8/11/17	The following was accomplished for the deficiency cited: 1.)A request for proposal was sent out to one outside contractor for performing fire and smoke damper inspection services on the four of four resident units in the facility. On 8/1/17 a contractor was contracted for completion of the fire and smoke damper inspection. Contractor has confirmed that, due to previous engagements and schedule, the earliest date available for performing fire and smoke damper inspection services on the four of four resident units in the facility is 9/5/17. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) Entire facility had potential to be affected by the deficient practice 2.) The contractor, post inspection, will document and provide to the Director of Maintenance a complete damper inventory list with locations for four of four resident	09/05/2017

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K 521	Continued From page 3 tested, and they could not find any paperwork regarding the smoke dampers. 2. Observations above the suspended ceiling on 7/11/17 from approximately 9:40 a.m. to 10:15 a.m. revealed mechanical and electrical hardware for smoke dampers attached to ventilation ducts that passed through the smoke barrier walls above the cross-corridor doors on the Autumn View, Canal View, Garden View, and Orchard View units. The 2010 edition of NFPA 80, Standard for Fire Doors and Other Opening Protectives, requires fire dampers to be tested and inspected one year after installation and every four years thereafter. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in place if so equipped. The 2010 edition of NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives, requires each smoke damper to be tested and inspected one year after installation. The test and inspection frequency shall then be every four years. [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 101: 19.5.2.1, 9.2.1; 2012 NFPA 90A: 5.4.8.1, 5.4.8.2; 2010 NFPA 80: 19.4.1, 19.4.1.1, 19.4.4; 2010 NFPA 105: 6.5.2, 6.5.5]	K 521	units. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) The Director of Maintenance/designee will schedule a future fire and smoke damper inspection service on the four of four resident units in the facility, not to exceed the first day of August in the year 2021. 2.) The Director of Maintenance/designee will retain a copy of the fire and smoke damper inspection certificate from the four of four resident units in the facility. The certificate copy will be located in the facility master QA binder. The certificate will be reviewed in the facility Quality Assurance meetings to ensure compliance. The Director Of Maintenance will monitor for overall compliance of this plan of correction.	
K 918 SS=C	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly	K 918 Accepted POC 8/11/17 JL	The following was accomplished for the deficiency cited: 1.) The Director of Maintenance located the keys for the Onan GenSet generator and locked the two of four open access panels. The following corrective actions have been	08/18/2017

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K 918	Continued From page 4 test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews conducted during the Life Safety Code Survey, it was determined that for two of two emergency generators, the facility did not properly maintain the emergency power supply. Issues included a lack of written records of runs and inspections, full load tests were conducted at intervals exceeding 40 days, and outside generator access panels were left unlocked. The findings are:	K 918	implemented to identify other areas that may have similar potential to be affected: 1.) The Director of Maintenance checked the Detroit Diesel access panels to ensure they were locked. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) A 'Monthly Test Log' for both the Onan and Detroit Diesel generators was developed by the Director of Maintenance to ensure a permanent record of the emergency power system's monthly testing, exercising and operation is maintained and available. 2.) A 'Weekly Inspection Checklist' for both the Onan and Detroit Diesel generators was developed by the Director of Maintenance to ensure a permanent record of the emergency power system's inspection and any necessary repairs is maintained and available. 3.) An audit the 'Monthly Test Log' and 'Weekly Inspection Checklist' will be conducted by the Administrator for a 3 month period to ensure that weekly inspections are completed for both the Onan and Detroit Diesel generators, and monthly testing is completed 4.) An audit of the 'Monthly Test Log' will be conducted by the Administrator for a 3 month period to ensure that monthly testing, no less than 20 days and no greater than 40 days, is completed for both the Onan and Detroit Diesel generators.	

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K 918	Continued From page 5 1. Observations on 7/10/17 at approximately 1:15 p.m. revealed two emergency generators located outside the facility. An Onan GenSet generator was observed to have two of the four access panels equipped with key locks, but the two panels could be readily opened without using a key. A Detroit Diesel generator was also located next to the Onan generator. When interviewed at that time, the Director of Maintenance said the Onan generator supplies emergency power to the older section of the building (Autumn View), and the Detroit Diesel generator supplies emergency power to the new sections of the facility (Orchard View, Canal View, Garden View). 2. On 7/10/17 from approximately 2:25 p. m. to 3:05 p.m. inspection and testing records for the emergency generators were reviewed. The records showed that there were no documented weekly inspections of the Onan generator since 5/26/17 and no documented weekly inspections of the Detroit Diesel generator since 12/30/16. Additionally, the records showed full load testing of the Onan generator exceeded 40 days between 6/26/17 and 4/28/17, and between 12/30/16 and 11/3/16. The records also showed full load testing of the Detroit Diesel generator exceeded 40 days between 12/30/16 and 11/3/16. In an interview at that time, the Director of Maintenance stated that weekly no load runs and monthly load runs had been conducted for both generators, but he just has not written anything down yet. The 2010 edition of NFPA 110, Standard for Emergency and Standby Power Systems, requires a permanent record of the emergency power system inspections, tests, exercising, operation, and repairs shall be maintained and readily available. The permanent record shall	K 918	5.) Audit results will be reported & reviewed in the facility Quality Assurance meetings The Director Of Maintenance will monitor for overall compliance of this plan of correction.	

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K 918	Continued From page 6 include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. Emergency Power Systems, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. Minimizing the possibility of damage resulting from interruptions of the emergency source (such as vandalism and sabotage) shall be a design consideration for emergency power supply equipment. The 2012 edition of NFPA 99, Health Care Facilities Code, requires generator sets to be tested 12 times a year with testing intervals of not less than 20 days, nor more than 40 days. [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 101: 19.5.1.1, 9.1.3.1; 2010 NFPA 110: 8.3.4, 8.3.4.1, 8.4.1, 7.2.4; 2012 NFPA 99: 6.4.4.1.1.4]	K 918		
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920 Accepted pre 8/11/17	The following was accomplished for the deficiency cited: 1.): a.) the six-receptacle plug extender attached to a duplex electrical wall outlet on the Autumn View Unit alcove near the entrance/exit has been removed. b.) the two power strips connected to each other in series and in use in the basement laundry room on a counter near the dryers were removed. c.) the six-receptacle plug extender	08/18/2017

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K 920	Continued From page 7 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observations made during the Life Safety Code Survey, it was determined that for four (Autumn View, Canal View, Garden View, and Orchard View) of four resident units and one of one basement, the facility did not properly maintain electrical equipment. Specifically, multi-plug adaptors used in resident rooms were not properly listed for their use, and power strips and/or multiplug adaptors were used in series (daisy chained). The findings are: 1. Observations in the presence of the Director of Maintenance during the initial tour of the facility on 7/10/17 from approximately 10:45 a.m. to 11:20 a.m. revealed the following: a. There was a six-receptacle plug extender attached to a duplex electrical wall outlet on the Autumn View Unit alcove near the entrance/exit. There were power leads from a microwave, television, DVD player, and two refrigerators attached to the plug extender, and the plug extender lacked over current protection. b. There were two power strips connected to each other in series and in use in the basement laundry room on a counter near	K 920	connected to a duplex outlet behind a fish tank in the main dining room that serves the Canal View, Orchard View, and the Garden View Units has been removed. d.) the six-receptacle plug extender attached to a duplex electrical wall outlet in the Garden View clean utility room has been removed. 2.) the six-receptacle plug extender attached to a duplex electrical wall outlet in Resident Room #210 on the Autumn View Unit has been removed. 3.) the six-receptacle plug extender attached to a duplex electrical wall outlet in Resident Room #218 on the Autumn View Unit has been removed. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) All resident rooms and common areas in four of four resident units and the basement were inspected by the Director of Maintenance for daisy chained power strips and six receptacle plug extenders. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) The Director of Maintenance will conduct a monthly audit of resident rooms and common areas in four of four resident units and the basement for the presence of daisy chained power strips and six receptacle plug extenders. Any daisy	

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K 920	Continued From page 8 the dryers. c. There was a six-receptacle plug extender connected to a duplex outlet behind a fish tank in the main dining room that serves the Canal View, Orchard View, and the Garden View Units. The six-receptacle plug extender was also connected to a power strip that was in use. d. There was a six-receptacle plug extender attached to a duplex electrical wall outlet in the Garden View clean utility room, and in use with three "Invacare" lift batteries that were charging. The plug extender lacked over current protection. 2. Observations on 7/11/17 at approximately 11:05 a.m. revealed a six-receptacle plug extender attached to a duplex electrical wall outlet in Resident Room #210 on the Autumn View Unit. The plug extender lacked over current protection. 3. Observations on 7/12/17 at approximately 9:05 a.m. revealed a six-receptacle plug extender attached to a duplex electrical wall outlet in Resident Room #218 on the Autumn View Unit. The plug extender lacked over current protection. The 2012 edition of NFPA 99, Health Care Facilities Code, requires all adaptors, extension cords, and attachment plugs to be listed for their purpose. The survey and certification letter 14-46-LSC issued by the Centers for Medicare and Medicaid Services requires power strips used in conjunction with non-patient care related electrical equipment to be UL-1363 (relocatable power taps). Power strips used in conjunction with patient care related electrical equipmant	K 920	chained power strips and six receptacle plug extenders found will be noted on the audit and removed. 2.) Audit results will be reported & reviewed in the facility Quality Assurance meetings The Director Of Maintenance will monitor for overall compliance of this plan of correction.	

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K 920	Continued From page 9 must be UL-1363-A or UL-60601-1 (special purpose relocatable power taps). Power strips cannot be "daisy chained." [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 99: 10.2.4.2, 10.2.4.2.1, 10.2.4.2.2; CMS S&C: 14-46-LSC]	K 920		
K 921 SS=E	NFPA 101 Electrical Equipment - Testing and Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	K 921 Accepted POC 8/10/17	The following was accomplished for the deficiency cited: 1.) A policy regarding the maintenance and testing of patient care related electrical equipment (PCREE) and non-patient care related electrical equipment was written. a.)maintenance manuals for the Schuco suction machines were obtained. b.)maintenance checks for battery powered lifts were completed. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) A policy regarding the maintenance and testing of patient care related electrical equipment (PCREE) and non-patient care related electrical equipment was written. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) The Director of Maintenance will be educated on the policy regarding the maintenance and testing of patient care related electrical equipment (PCREE) and non-patient care related electrical equipment.	08/18/2017

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K 921	Continued From page 10 This STANDARD is not met as evidenced by: Based on observations, an interview, and record reviews conducted during the Life Safety Code Survey, it was determined that the facility did not properly maintain and test patient care related electrical equipment. Specifically, there were no policies regarding the maintenance and testing of patient care related and non-patient care related electrical equipment, there were no maintenance manuals for suction machines, and there were no maintenance checks for battery powered lifts. The findings are: 1. Observations on 7/11/17 from approximately 10:45 a.m. to 11:10 a.m. revealed the following: a. There was a Schuco brand suction machine on a crash cart in the common dining room that serves the Orchard View, Canal View, and Garden View units. b. Two "THE" Medical Ultralift 3500 battery powered lifts were in the hallway outside Resident Rooms #41 and #12 (Canal View and Garden View). c. There was a Vision Aire 5 oxygen concentrator in use in Resident Room #14 (Garden View). Further observations of both of the "THE" Medical lifts revealed the housing for the controls on the main frames were broken and held together in place with clear tape. 2. On 7/11/17 from 12:57 p.m. to 1:20 p. m., manufacturer's specification booklets were provided for the "THE" Medical Ultralift 3500.	K 921	2.) The Director of Maintenance will develop a list of equipment that will receive an inspection based on service manuals and instructions provided by the equipment manufacturers. 3.) The Director of Maintenance will develop and maintain a permanent file for service manuals and instructions. 4.)An electrical inspection log will be maintained by the Director of Maintenance on every item of patient care related electrical equipment (PCREE) and non-patient care related electrical equipment. Each month the Director of Maintenance and Administrator will review the electrical inspection log. 5.) The electric inspection log review will be reported & reviewed in the facility Quality Assurance meetings The Administrator/designee will monitor for overall compliance of this plan of correction.	

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K 921	Continued From page 11 Section 5 of the manual stated that the lift requires regular maintenance and a monthly maintenance schedule is recommended. The manual also documented that it is important that regular service and maintenance checks are performed on the patient lifts and the actuators to avoid the risk of accidents and personal injury. The manual documented: the actuator should be checked within a period of maximum three years or more often if used with a high frequency in an institutional environment. An interview with the Director of Maintenance revealed there is no preventative maintenance done on the lifts and that he just changes the batteries when needed. 3. When interviewed on 7/11/17 at approximately 2:20 p.m., the Direcor of Maintenance said there were no service manuals available for the Schuco brand suction machine. Also, there were no policies and procedures for testing and maintenance of patient care related electrical equipment. He said the facility is in the process of putting together a program. The 2012 edition of NFPA 99, Standard for Health Care Facilities, requires facilities to establish policies and protocols for the type of test and intervals of testing for patient care-related electrical equipment. Policies shall be established for the control of appliances not supplied by the facility. Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment. A permanent file of instruction and maintenance manuals shall be maintained and be accessible. A record shall be maintained of the tests required by this chapter and associated repairs or modifications.	K 921		

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K 921	Continued From page 12 [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 99: 10.5.2.1.1, 10.5.2.7, 10.5.3.1.2, 10.5.6.1.1, 10.5.6.2.1, 10.5.6.2.2]	K 921		

EXHIBIT 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580 SS=G	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580	F580 The facility does inform the resident, consult with a physician; and notify, consistent with his or her authority , the resident's representative when there is a change of condition, accident & incident; significant change in condition; change in treatment; decision to discharge or transfer; room change; update mailing addresses; etc. 1. The medical record for Resident #1 and #2 were reviewed with the Medical Director to identify when and where the significant change occurred and when and where the notification to the physician failed. After review with the Medical Director, the Director of Nurses will meet and educate the nursing administration team of the findings of those reviews. Licensed nurses for Resident #1 and #2 were educated and/or disciplined. 2. The facility policy and procedure for a significant change of condition and wound documentation was reviewed and modified with the Medical Director. All full and part-time licensed nurses were educated on these policies and received a post-test respectively by the Director of Nurses/designee. The certified nursing assistants were educated on the facility policy and procedure for a significant change of condition and when to report by the Director of Nursing/designee. A CNA reporting form for change in condition was instituted and CNA's were in-serviced on how to use it to report any change in condition with a resident by the Director of Nursing/designee. The change in condition form includes any skin concerns and is turned in to the LPN/RN charge nurse to assess and then contact MD to update on	03/23/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	03/23/2018

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00215119) completed on 2/21/16, the facility did not immediately consult with the resident's Physician when there was a significant change in the resident's condition and a need to alter treatment significantly for two (Residents #1, 2) of three residents reviewed for physician notification. Specifically, nursing staff did not consult with the physician when Resident #1 experienced abdominal distention with multiple episodes of vomiting, rectal bleeding, weakness, and abnormal vital signs. Subsequently, the resident expired prior to being transported to the hospital. Additionally, the Physician was not notified when Resident #2 developed skin concerns. This resulted in actual harm that is not immediate jeopardy for Resident #1. The findings are: 1. Resident #1 was admitted to the facility on 11/14/17 with diagnoses of gastrointestinal bleed, gastroenteritis and colitis (inflammation of the stomach or intestine due to infection). Review of the Minimum Data Set (MDS - a resident assessment tool) dated 12/02/17	F 580	condition and obtain new order. A random audit of all hospital discharges or expirations from February 21, 2018 forward will be completed and one chart review each week x six weeks will be discussed at morning clinical meeting with the nursing administration team by the Director of Nurses/designee. 3. During morning clinical meeting, direction will be given by the Director of Nurses to the licensed staff as to required follow up for a perceived change in condition. In the event the RN is not available to assess the resident within an hour of the identified change, the Director of Nurses will be contacted for direction and recommendations as to how to proceed. The twenty-four hour report will be reviewed daily for any change in condition for a resident and the DON/RN designee will assess as needed. On weekends the RN in the building will review the 24 hour report sheets and take appropriate action for any changes in condition including calling MD and responsible party. If this occurs on a shift with no RN, the LPN charge will call the Director of Nursing who is on call 24/7 for instruction on what she needs to do. A change of condition audit/reporting tool will be developed and utilized by the Unit Managers on a daily basis for any identified change of condition in a resident and review with the DON/designee for appropriate and timely follow-up with the physician and responsible party. 4. Twenty-four hour reports and progress notes will be reviewed on a daily basis by the Director Of Nursing/designee that the MD and responsible party were notified by the unit LPN/RN charge nurse. The	

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F 580	Continued From page 2 documented the resident was moderately cognitively impaired. A facility policy entitled "Change in Condition: When to report to the MD/NP/PA (Medical Doctor/Nurse Practitioner/Physician Assistant" dated 2014 revealed that any symptom, sign or apparent discomfort that is acute or sudden in onset, a marked change (more severe), or unrelieved by measures already prescribed, there should be immediate notification. This includes but not limited to; abdominal distention with vomiting (emesis), vomiting two or more times in 12 hours; and abrupt onset of general weakness with other acute symptoms. The undated comprehensive care plan documented the resident was non- ambulatory, had required the assist of two staff members for transfer, and was incontinent of urine. There was no care plan developed for bowel elimination or the use of antiplatelet medications (reduce the ability of platelets to stick together and inhibit the formation of blood clots). The Physician's Orders dated 12/31/17 documented the resident was ordered the following medications that included: - Aspirin 81 mgs (milligrams) one tablet daily by mouth for coronary artery disease. - Plavix (an antiplatelet medication) 75 mgs one tablet daily by mouth for coronary artery disease. - Milk of Magnesia (used to treat occasional constipation) 30 mls (milliliters) as needed at bedtime if there was no bowel movement for three days. - Dulcolax suppository (used to treat occasional constipation) 10 mgs as needed if there was no bowel movement from the Milk of Magnesia;	F 580	findings of both audits will be summarized and presented at the monthly QA meeting for further recommendations and discussion by the committee. The DON is responsible for this plan of correction and supervised by the Administrator.	

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F 580	Continued From page 3 insert 1 suppository rectally the same day. - Saline enema (injection of fluid into the lower bowel by way of the rectum, used to relieve constipation) as needed if there was no bowel movement from the Dulcolax suppository. - Colace 100 mgs give one capsule by mouth daily as needed for a laxative. - Humalog Insulin inject subcutaneously (beneath the skin) before meals and at bedtime per sliding scale (progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges). The "Complex Alert Documentation Report" regarding bowel movements dated 2/1/18 to 2/15/18 documented the resident had bowel movements on 2/2/18, 2/3/18, and 2/5/18. The Medication Administration Record (MAR) for February 2018 documented the resident received Milk of Magnesia on 2/9/18 at 1:00 PM, and a Dulcolax suppository on 2/10/18 at 10:30 PM. The nursing Progress Notes dated 2/11/18 documented the following: - 2:23 AM - The Licensed Practical Nurse (LPN #1) documented at the start of the shift the resident had multiple episodes of emesis that contained undigested food. The resident's abdomen was firm and distended with positive bowel sounds in all four quadrants. An as needed Bisacodyl suppository was given for constipation. There was a scant amount of rectal bleeding after the administration of the suppository. The following vital signs were documented: blood pressure (B/P)123/60 (normal is 120/80), pulse (P) 91 (normal is 60 to 100 beats per minute), respirations (R) 16 (normal is 12 to 20 breaths per minute) and	F 580		

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F 580	Continued From page 4 were unlabored. The resident's temperature (T) was 97.6 Fahrenheit (F) (normal is 97.7-99.5 °F). - 3:50 AM - LPN #1 documented that the resident yelled out "help me". The writer went to the resident's room and the resident had requested to go to the bathroom. The resident was weak and unable to sit up on the toilet without assistance from staff. The resident's vomiting had subsided. - 4:10 AM - LPN #1 documented the following vital signs: B/P 156/84, (TPR) 98.4 - 54 -16, SPO2 (amount of oxygen in the blood) 96% (percent) (normal is between 95 and 100 percent) on room air. Additionally, the resident had a blood glucose of 298 (normal is 70 to 110). The resident continued with a scant amount of rectal bleeding. The Supervisor (RN #1) was made aware. - 4:24 AM - Registered Nurse (RN #1) documented she was in the bathroom with the resident and the resident was unable to have a bowel movement. The resident was having trouble staying awake and was put back to bed. The resident had vomited twice in the past hour, her belly was soft and did not complain of pain when her belly was palpated. - 5:37 AM - LPN #1 documented the resident's abdomen remained distended, but was less firm. The resident was passing gas and had positive bowel sounds in all four quadrants. A scant amount of rectal bleeding continued and the Supervisor was made aware (RN #1). - 7:55 AM - RN #1 documented she went in to see the resident after being alerted by the aide that the resident seemed to be having trouble breathing. The resident was sitting in a wheelchair and was held up by two staff members. The resident's color was drained from her face and she was not responding to voice or pain stimuli. The resident's vital signs were: BP	F 580		

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F 580	Continued From page 5 53/39, P 92, PO2 74 %. - 7:59 AM - RN #1 documented the resident's abdomen was distended and bowel sounds were absent in three quadrants and were very diminished in the lower left quadrant. The resident's color had returned to her face but her breathing was labored. - 8:49 AM - RN #1 documented that she had spoken with the Physician and was advised to send the resident to the hospital for an evaluation. 911 was called. The resident was unresponsive, had a B/P of 39/20 and had left on a stretcher at 8:45 AM. - 12:09 PM - LPN #3 documented the ambulance arrived at facility at 8:30 AM to transport the resident. The resident's blood pressure had continued to drop and the resident's breathing became labored with periods of apnea (suspension of external breathing). Staff received a phone call from a member of the ambulance team the resident expired in the ambulance prior to leaving the parking lot. An ambulance report entitled "Prehospital Care Report" dated 2/11/18 documented the 911 call was received at 8:24 AM. The ambulance was dispatched at 8:25 AM, arrived on the scene at 8:30 AM and had resident contact at 8:31 AM. The narrative note documented the resident was found in bed having agonal respirations (gasping respiration). The resident was moved to the ambulance. The resident stopped breathing and artificial respirations had begun. Due to the resident's DNR/DNI (Do not Resuscitate (No cardiopulmonary resuscitation (CPR)/ Do Not Intubate (no breathing tubes to be placed) status, the resident was not intubated. The resident's heart stopped at 8:42 AM. The 24-Hour Report dated "2/11/18" on the 10:	F 580		

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F 580	Continued From page 6 00 PM to 6:00 AM shift (the shift started on 2/10/18 at 10:00 PM and goes through 2/11/18) documented the resident's abdominal was firm, distended with positive bowel signs in four quadrants. The resident had multiple episodes of emesis with undigested food particles. An as needed Bisacodyl was given, there was a scant amount of rectal bleeding. Results from the suppository were pending. There were no other notations for this resident on the previous shifts. During an interview on 2/14/18 at 11:50 AM, the Physician did not know the resident was having these issues during the night on 2/11/18 stating, "this is news to me". The staff should have called her earlier if the resident was having emesis that contained undigested food or had vomited more than once on a shift. The physician's expectation was that staff call her if any resident was having any kind of acute symptoms. Additionally, if the staff could not get a hold of her for whatever reason, the staff should then call the Medical Director or whatever doctor was on call. The Physician further stated that she received a call at approximately 8:20 AM on 2/11/18 concerning the resident's condition. During an interview on 2/15/18 at 6:15 AM, LPN #1 stated when she came on duty on 2/10/18 (10:00 PM to 6:00 AM shift) she did not see any documentation the resident had a bowel movement, so she gave the resident a Dulcolax suppository. At approximately 12:00 PM midnight the resident had emesis, she helped the aides clean her up and change her bedding. She stated that she informed RN #1 on several occasions that morning whenever the resident vomited or the resident's vital signs were taken. The last time she saw the resident was at approximately 5:45 AM with LPN #2. The	F 580		

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F 580	Continued From page 7 resident's abdomen was not as distended as it was at the beginning of the shift and the resident was passing gas. She believed that LPN's were not to call the physician but RN's do if a resident had a change in condition. She believed RN #1 was going to call the physician about the resident and she left for the day at 6:00 AM. During an interview on 2/15/18 at 6:44 AM, RN #1 stated she was not aware of a second set of vitals that were taken on 2/11/18 at approximately 4:00 AM. She assessed the resident at that time but did not document her findings. The resident's abdomen was distended but the resident did not have pain or tenderness. She would have called the physician earlier if she had known about the second set of vitals or the resident had undigested food in her emesis. The resident was vomiting at the nurse's station and it was only liquid at approximately 11:00 PM on 2/10/18. She had paged the physician at 7:30 AM on 2/11/18 and did not get a response. LPN #2 had paged the Physician at approximately 7:40 AM. The Physician called back around 8:00 AM and gave the order to send the resident to the hospital. During an interview on 2/15/18 at 7:09 AM, LPN #2 stated she saw the resident at approximately 6:30 AM on 2/11/18. She performed a digital exam and the resident had stool in her rectum. The resident's abdomen was soft and she had bowel sounds. She gave the resident an enema at 6:40 AM because the resident did not have any results from the suppository. Around 7:00 AM, RN #1 said, the resident's blood pressure was low and to call the Physician. LPN #2 paged the Physician around 7:00 AM. LPN #3 then came in and took over for the night shift. LPN #2 did not document any of her notes because by the time she was ready to document the	F 580		

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F 580	Continued From page 8 resident's medical record had been inactivated and she no longer had access to the record. During an interview on 2/15/18 at 8:07 AM, LPN #3 stated that she arrived at work approximately 8:10 AM. RN #1 was sitting at the nurse's station. She went to see the resident in her room and the resident was a grayish color and was barely breathing. She called 911 at approximately 8:30 AM. She asked RN #1 what happened, and RN #1 stated to her, "silly me, I should have assessed her (the resident) earlier". After the ambulance crew left at approximately 9:30 AM, she called the Director of Nursing and told her what happened. During an interview on 2/15/18 at 8:20 AM, Certified Nurse Aide (CNA #2) stated she came on duty at 6:00 AM on 2/11/18 and the resident was yelling. She went to check on the resident and the resident wanted to go to the bathroom. She tried to the get the resident to sit up but the resident just "flopped back" onto the bed. She reported this to LPN #1 and was told the resident's vitals were "fine". CNA #2 told the other nurse (LPN #2), and LPN #2 said she gave the resident an enema. The resident kept yelling out between 6:00 AM and 8:00 AM on that morning but the resident did have a habit of doing that. CNA #2 and CNA #3 went to check on the resident at 7:20 AM and that the resident's breathing was shallow. CNA #2 went to get the agency nurse who was on duty that morning. The agency nurse took the resident's vitals and that the resident left on an ambulance. During an interview on 2/15/18 at 8:30 AM, CNA #3 stated she had worked the 2:00 PM shift to 10:00 PM shift on 2/10/18. She helped put the resident to bed at approximately 10:00 PM. The resident was her "usual self", yelling at people or	F 580		

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F 580	Continued From page 9 kicking staff. When she left for the night the resident was "fine". When she came on 2/11/18 at 6:00 AM, CNA #2 asked her for her help in getting the resident out of bed and believed it was between 7:00 AM and 7:30 AM. When she saw the resident, the resident was "super pale" and her cheeks were "drooping". This was not normal for this resident. She went and got LPN #2. The nurse told her the resident was trying to have a bowel movement and to put the resident back in to bed. During an interview on 2/15/18 at 12:30 PM, the Director of Nursing (DON) stated she expected her RN's to do assessments on a resident with acute symptoms and to call the physician right away if the resident was having acute symptoms. If the LPN or the RN felt uncomfortable calling a Physician for whatever reason, she was always available and they could call her. The RN should not make a judgement call and that it should be up to the Physician. During an interview on 2/20/18 at 2:40 PM, CNA #4 stated she worked a double shift from 3:00 PM on 2/10/18 to 6:00 AM on 2/11/18. The resident was in bed sleeping at 10:00 PM on 2/10/18. At approximately 11:30 PM, the resident had vomited all over herself and her bedding. She told LPN #1 what happened, they cleaned up the resident and did a complete bed change. At approximately 2:00 AM the resident was calling out to go to the bathroom, she got her to the bathroom but the resident couldn't sit up by herself. She informed RN #1 about the resident being very weak while sitting on the toilet. At 4:00 AM, the resident had again thrown up a little, she cleaned her up and notified LPN #1. LPN #1 asked her to take the resident to the toilet. She and the other aide did	F 580		

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F 580	Continued From page 10 not feel comfortable taking her because the resident was so weak. CNA #4 told RN #1 about the resident being weak. During an interview on 2/20/18 at 2:55 PM, CNA #5 stated at 10:00 PM on 2/10/18 the resident was in her bed. At about 12:00 midnight the resident had thrown up. CNA #5 and CNA #4 cleaned up the resident and changed the resident's bed. She let LPN #1 know about the resident vomiting. LPN #1 wanted the resident to go to the bathroom at around 2:00 AM. The resident was weak and couldn't sit up while on the toilet. She told RN #1 about the resident at approximately 2:00 AM but could not say if the RN went to see her. At 4:00 AM, the resident was pale like a "sheet of paper". She voiced her concerns about the resident to RN #1 and that RN #1 needed to go and see her. 2. Resident #2 was admitted to the facility on 3/26/13 with diagnoses of dementia and noncancerous enlargement of the prostate gland. Review of the MDS dated 12/13/17 documented the resident was mildly cognitively impaired. Review of a policy and procedure entitled "Wound Documentation" dated 6/2016 revealed the RN is to assess the wound and obtain an order from the physician to treat the wound. The comprehensive care plan dated 12/20/17 documented the resident required the assistance of two people for toileting and personal hygiene. The resident was to be toileted every two to three hours. A Nursing Progress Note dated 1/19/18 documented the resident had an excoriation of the genital area. The Nursing supervisor was	F 580		

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F 580	Continued From page 11 notified and Calasoothe (a moisture barrier ointment that helps heal irritated skin) was applied. Review of the resident's medical record revealed there was no documented evidence the physician was notified of the skin concern, or a physician's order was obtained for the Calosoothe. A Nursing Progress Note dated 1/28/18 documented there were red, open areas noted to the resident's genital area and a new order was obtained for Calosoothe to be applied every shift and as needed. Physician's Orders dated 1/28/18 revealed that an order for Calosoothe was to be applied every shift and as needed to the resident's genital area. During an interview on 2/14/18 at 12:30 PM, Registered Nurse (RN #2) stated that Calosoothe needed to have a physician's order to be applied. If the Calosooth was applied without an order, the physician should have been called right away to obtain an order. During an interview on 2/14/18 at 12:45 PM, Certified Nurse Aide (CNA #3) stated the resident had the skin condition for approximately three weeks and they had only been applying the Calosoothe for a week and a half. During an interview on 2/15/18 at 6:45 AM, RN #1 stated she was aware of the excoriated area on the resident's genitals on 1/19/18. She did not notify the physician about the area and did not obtain an order to apply the Calosoothe. During an interview on 2/15/18 at 12:00 PM, the	F 580		

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F 580	Continued From page 12 Director of Nursing (DON) stated she expected her staff to report the skin issues to the Physician. 415.3(e)(2)(ii)(b)	F 580		
F 684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint NY00215119) completed on 2/21/18, it was determined the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice. One (Resident #2) of three residents reviewed for quality of care lacked an assessment of an identified non-pressure related skin concern and a medicated ointment was applied without a Physician's order. The findings are: Review of a policy and procedure entitled "Wound Documentation" dated 6/2016 revealed the RN is to assess the wound and obtain an order from the physician to treat the wound. 1. Resident #2 was admitted to the facility on 3/26/13 with diagnoses of dementia and	F 684	F684 Residents of this facility do receive treatment and care in accordance with professional standards and practices. 1. A medication error form was completed for the medication utilized without a physician order for Resident #2. A head-to-toe assessment of Resident #2 was completed by the DON to confirm what if any skin issues remain and the MD contacted if needed. 2. All full and part-time licensed staff will be re-educated and a post test given as it relates to wound identification, physician notification and obtaining treatment orders in a timely manner by the licensed nurse identifying the skin area. A skin problem sheet will be educated to the aides & LPN's for timely follow-up for any potential skin issues identified by the licensed nurse/skin team. This skin problem sheet will be distributed by the skin team nurse on a weekly basis indicating location of skin issue and treatment to be applied. The DON/designee will be responsible for education to the licensed nurses and the certified aides. 3. All existing treatments will be verified that a physician order exists for that current treatment by skin nurse/designee. The results of that audit will be conducted by the Unit Managers and given to the DON/designee for review.The skin monitoring/assessment sheet will contain skin issue, MD treatment order, and note that Care plan and care guides were	03/23/2018

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F 684	Continued From page 13 noncancerous enlargement of the prostate gland. Review of the Minimum Data Set (MDS- a resident assessment tool) dated 12/13/17 documented the resident was mildly cognitively impaired. The comprehensive care plan dated 12/20/17 documented the resident required the assistance of two people for toileting and personal hygiene. The resident was to be toileted every two to three hours. A Nursing Progress Note dated 1/19/18 documented the resident had an excoriation of the genital area. The Nursing supervisor was notified and Calasoothe (a moisture barrier ointment that helps heal irritated skin) was applied. Review of the resident's medical record revealed there was no documented evidence the physician was notifled of the skin concern, or a physician's order was obtained for the Calosoothe. A Nursing Progress Note dated 1/28/18 documented there were red, open areas noted to the resident's genital area and a new order was obtained for Calosoothe to be applied every shift and as needed. Physician's Orders dated 1/28/18 revealed that an order for Calosoothe was to be applied every shift and as needed to the resident's genital area. During an interview on 2/14/18 at 12:30 PM, Registered Nurse (RN #2) stated that Calosoothe needed to have a physician's order to be applied. If the Calosooth was applied without an order, the physician should have	F 684	updated as needed will be reviewed at the daily clinical morning meeting by DON, MDS coordinator, skin nurse and Unit charge nurses. Those skin monitoring/assessment sheets will be given to the skin team leader for review. The facility policy will be updated as necessary to reflect the procedural changes by the Director of Nurses/designee. The facility skin nurse to monitor. 4. The skin monitoring/assessment sheets will be summarized for the current month to reflect compliance in timely identification, MD notification, treatment order, care plan and care guide update for all newly identified skin issues by Unit Managers and communicated at the monthly QA meeting for further recommendations and communication by the committee. The DON will be responsible for the plan of correction and monitored by the Administrator.	

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F 684	Continued From page 14 been called right away to obtain an order. During an interview on 2/14/18 at 12:45 PM, Certified Nurse Aide (CNA #3) stated the resident had the skin condition for approximately three weeks and they had only been applying the Calosoothe for a week and a half. During an interview on 2/15/18 at 6:45 AM, RN #1 stated she was made aware of the excoriated area on the resident's genitals on 1/19/18 but did not assess or document the skin issue. RN #1 did not fill out a wound treatment sheet for the excoriation, did not notify the physician about the skin concern nor did she obtain an order to apply the Calosoothe. Interview on 2/15/18 at 2:00 PM with the Director of Nursing (DON) revealed that she expected her staff to measure any skin condition found on a resident, do an assessment of the skin issues, and report the skin issues to the physician. 415.12	F 684		
F 842 SS=D	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842	F842 The facility does maintain medical records on each resident in accordance with acceptable professional standards and practices that are complete and accurately documented. 1. The bowel movement record and nursing assessments for Resident #1;and skin assessment for the excoriation for Resident #2 was reviewed with the Medical Director for recommendations. In addition, the policy on documenting on the BM Record and skin assessment policy will be reviewed and updated with the Medical Director, DON and Administrator. All full and part-time licensed and certified staff were educated on the BM protocol.	03/23/2018

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F 842	Continued From page 15 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	2. All full and part-time licensed staff will be re-educated by DON/designee on the requirements for documentation for identifying and reporting skin issues and the facility policy and procedure for the BM protocol. The certified aides will be re-educated by DON/designee as to the necessity of completing the BM log so the licensed nurse has complete information to adhere to the BM protocol. A post-test will be given to each job class(licensed nurses and certified aides) as it relates to their responsibilities. 3. A audit for the BM protocol will be developed and the Unit Managers will be responsible for auditing daily before the end of their shift that the BM log has been completed. A skin alert sheet will be developed for the aides to complete and given to the licensed nurse for data collection and communication to their Unit Manager and obtaining treatment orders from the physician. All audits and skin alert sheets will be reviewed at the morning clinical meeting. Copy of skin sheets will be given to the skin team RN for medical record documentation, and audits will be given to and reviewed by the DON. 4. A random audit of no less then one record on each unit if identified will be reviewed between the skin alert sheet and the date of the physician order for a treatment will be completed each month for four months by the DON/designee. The results will be discussed at the monthly QA meeting for further recommendations and follow-up by the DON. 5.Direct staff involved with resident #1 where educated that if RN charge does not call MD or perform assessment, the LPN should gather data and call Director of	

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F 842	Continued From page 16 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview conducted during an Abbreviated survey (Complaint #NY00215119), it was determined that the facility did not maintain medical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented. Two(Residents #1, 2) of three residents reviewed for complete and accurate medical records had issues with an incomplete bowel movement record and nursing assessments that were not documented in the medical record for Resident #1; and the lack of a documented assessment when the resident had an identified excoriation of the genital area for Resident #2. The findings are: 1. Resident #1 was admitted to the facility on 11/14/17 with diagnoses of gastrointestinal bleed, gastroenteritis and colitis (inflammation of the stomach or intestine due to infection). Review of the Minimum Data Set (MDS - a resident assessment tool) dated 12/02/17 documented the resident was moderately	F 842	Nursing at home if she is not in the building; the DON will instruct LPN on what to do. RN's were educated of importance of accurate and complete nursing assessments. 6. CNA's were educated on reporting skin conditions to their unit LPN, charge LPN or skin nurse. 7.RN #1 placed late assessment note in resident #1 progress notes and skin nurse was alerted to resident #2 skin condition and documentation was placed in progress notes of resident #2 chart and care plan updated. The DON/designee will review the BM log on a monthly basis for missed documentation and compare to the audit tool completed by the Unit Managers monthly for four months. The DON is responsible for this plan of correction and supervised by the Administrator.	

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F 842	Continued From page 17 cognitively impaired. The "Complex Alert Documentation Report" regarding bowel movements dated 2/1/18 to 2/15/18 documented the resident had bowel movements on 2/2/18, 2/3/18, and 2/5/18. The Medication Administration Record (MAR) for February 2018 documented the resident received Milk of Magnesia on 2/9/18 at 1:00 PM, and a Dulcolax suppository on 2/10/18 at 10:30 PM. A late entry nursing Progress Note dated 2/11/18 revealed that the resident had a bowel movement on 2/9/18 and that the Certified Nurse Aide was to record it on the bowel movement report. Review of the bowel movement report revealed there was no documentation that the resident had a bowel movement that day. During an interview on 2/15/18 at 6:15 AM, the Licensed Practical Nurse (LPN #1)stated she did not know the resident had a bowel movement on 2/9/18 because it wasn't documented in the bowel movement record. She gave the resident a suppository (medication for constipation) on 2/10/18 because she did not know that the resident had a bowel movement. Nursing Progress Notes dated 2/11/18 documented the following: - 2:23 AM - The Licensed Practical Nurse (LPN #1) documented at the start of the shift the resident had multiple episodes of emesis that contained undigested food. The resident's abdomen was firm and distended with positive bowel sounds in all four quadrants. An as needed Bisacodyl suppository was given for	F 842		

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F 842	Continued From page 18 constipation. There was a scant amount of rectal bleeding after the administration of the suppository. The following vital signs were documented: blood pressure (B/P)123/60 (normal is 120/80), pulse (P) 91 (normal is 60 to 100 beats per minute), respirations (R) 16 (normal is 12 to 20 breaths per minute) and were unlabored. The resident's temperature (T) was 97.6 Fahrenheit (F) (normal is 97.7-99.5 °F). - 3:50 AM - LPN #1 documented that the resident yelled out "help me". The writer went to the resident's room and the resident had requested to go to the bathroom. The resident was weak and unable to sit up on the toilet without assistance from staff. The resident's vomiting had subsided. - 4:10 AM - LPN #1 documented the following vital signs: B/P 156/84, (TPR) 98.4 - 54 -16, SPO2 (amount of oxygen in the blood) 96% (percent) (normal is between 95 and 100 percent) on room air. Additionally, the resident had a blood glucose of 298 (normal is 70 to 110). The resident continued with a scant amount of rectal bleeding. The Supervisor (RN #1) was made aware. - 4:24 AM - Registered Nurse (RN #1) documented she was in the bathroom with the resident and the resident was unable to have a bowel movement. The resident was having trouble staying awake and was put back to bed. The resident had vomited twice in the past hour, her belly was soft and did not complain of pain when her belly was palpated. - 5:37 AM - LPN #1 documented the resident's abdomen remained distended, but was less firm. The resident was passing gas and had positive bowel sounds in all four quadrants. A scant amount of rectal bleeding continued and the Supervisor was made aware (RN #1). - 7:55 AM - RN #1 documented she went in to	F 842		

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F 842	Continued From page 19 see the resident after being alerted by the aide that the resident seemed to be having trouble breathing. The resident was sitting in a wheelchair and was held up by two staff members. The resident's color was drained from her face and she was not responding to voice or pain stimuli. The resident's vital signs were: BP 53/39, P 92, PO2 74 %. - 7:59 AM - RN #1 documented the resident's abdomen was distended and bowel sounds were absent in three quadrants and were very diminished in the lower left quadrant. The resident's color had returned to her face but her breathing was labored. - 8:49 AM - RN #1 documented that she had spoken with the physician and was advised to send the resident to the hospital for an evaluation. 911 was called. The resident was unresponsive, had a B/P of 39/20 and had left on a stretcher at 8:45 AM. - 12:09 PM - LPN #3 documented the ambulance arrived at facility at 8:30 AM to transport the resident. The resident's blood pressure had continued to drop and the resident's breathing became labored with periods of apnea (suspension of external breathing). Staff received a phone call from a member of the ambulance team the resident expired in the ambulance prior to leaving the parking lot. During an interview on 2/15/18 at 6:44 AM with RN #1 revealed that she was not aware of a second set of vitals taken at approximately 4:00 AM. She assessed the resident at approximately 4:00 AM on 2/11/18 but she did not document her findings at that time. During an interview on 2/15/18 at approximately 1:00 PM, the Director of Nursing (DON) stated that she expected her staff to complete	F 842		

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F 842	Continued From page 20 documentation for bowel movements and other concerns for residents in a timely manner. 2. Resident #2 was admitted to the facility on 3/26/13 with diagnoses of dementia and noncancerous enlargement of the prostate gland. Review of the MDS dated 12/13/17 documented the resident was mildly cognitively impaired. The comprehensive care plan dated 12/20/17 documented the resident required the assistance of two people for toileting and personal hygiene. The resident was to be toileted every two to three hours. A Nursing Progress Note dated 1/19/18 by a Licensed Practical Nurse (LPN)documented the resident had an excoriation of the genital area. The Nursing supervisor was notified and Calasoothe (a moisture barrier ointment that helps heal irritated skin) was applied. Review of the resident's medical record revealed there was no documented evidence the physician was notified of the skin concern, or a physician's order was obtained for the Calosoothe. Additionally, there was no documented evidence there was an RN assessment of the identified skin concern on 1/19/18. A Nursing Progress Note dated 1/28/18 documented there were red, open areas noted to the resident's genital area and a new order was obtained for Calosoothe to be applied every shift and as needed. Physician's Orders dated 1/28/18 revealed that an order for Calosoothe was to be applied every shift and as needed to the resident's genital	F 842		

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	335212	A. BUILDING _____ B. WING _____	02/21/2018

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

(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) COMPLETE DATE
F 842	Continued From page 21 area. During an interview on 2/14/18 at 12:30 PM, Registered Nurse (RN #2) stated that Calosoothe needed to have a physician's order to be applied. If the Calosooth was applied without an order, the physician should have been called right away to obtain an order. During an interview on 2/14/18 at 12:45 PM, Certified Nurse Aide (CNA #3) stated the resident had the skin condition for approximately three weeks and they had only been applying the Calosoothe for a week and a half. During an interview on 2/15/18 at 6:45 AM, RN #1 stated she was aware of the excoriated area on the resident's genitals on 1/19/18. She did not assess the area, or make a notation about the skin concern. Review of the policy and procedure entitled "Wound Documentation" dated 6/2016 revealed that new wounds noted are to be properly documented and that an order must be obtained for treatment. 415.22(a)(1,2)	F 842		

EXHIBIT 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	11/16/2018

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

(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) COMPLETE DATE
F 561 SS=D	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #49) of one resident reviewed for choices, the facility did not allow each resident the right to make choices about aspects of life that were	F 561 Accepted 12/4/18 MO	The following corrective action has been implemented for the deficiency cited: 1)The bath schedule & Plan of care for Resident #49 was updated with her preference for number of showers/baths per week and the days she preferred to be showered/bathed. 2) A 100% audit was completed by Activities Dept. asking all residents how many showers a week they want, day of week they want their showers and what shift they would like their shower on. All Care plans were updated for the resident's preference. 3)A Policy was written for Resident Choices for Bathing. All nursing staff were educated on this policy. All residents will be questioned by Activities upon admission, & quarterly thereafter, as to frequency & time for their bathing; this will be included in resident plan of care and communicated to nursing dept. by the Activity Director, to implement/add to nursing bath schedule. 4) The Activity Director will present at the monthly QA meeting how many residents were interviewed on admission and how many re-interviewed per the quarterly MDS schedule. A compliance rate will be determined for each month. This audit will be conducted for 3 months, and recommendations to alter audit will be presented to QA committee once 100% compliance is reached for 2 months. The Activity Director is responsible for plan of correction and monitored by the Administrator for compliance	12/21/2018

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

Electronically Signed | 12/13/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	11/16/2018

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THE VILLAGES OF ORLEANS HEALTH AND REHAB CENTER	14012 ROUTE 31 ALBION, NY 14411

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F 561	Continued From page 1 significant to them. Specifically, the resident was not given the choice of how often to shower. This is evidenced by the following: Resident #49 was admitted to the facility on 11/24/14 and had diagnoses including multiple sclerosis, chronic obstructive pulmonary disease, and congestive heart failure. The Minimum Data Set Assessment, dated 2/26/18, revealed that the resident was cognitively intact, always incontinent of bowel, and that choosing between a shower and tub bath was very important. The current Comprehensive Care Plan and Shower Schedule revealed that the resident was showered once a week on Fridays (day shift). When interviewed on 11/9/18 at 10:57 a.m., the resident said that she could only get one shower a week. The resident said that she would like more than one shower a week. The resident said when she asked the staff she was told that she could only have one shower a week. During an interview on 11/14/18 at 10:01 a.m., the Certified Nursing Assistant said she did not know if the residents can have more than one shower a week or if anyone asks the residents about shower preferences. She said that the residents are added to the shower schedule and showed the surveyor the schedule. Interviews conducted on 11/15/18 included the following: a. At 10:42 a.m., the Registered Nurse Manager (RNM) said that residents are not asked about their bathing preferences (bed bath, tub, or shower) and/or frequency of bathing. She said the residents are scheduled weekly	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	11/16/2018

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F 561	Continued From page 2 based on their room number. b. At 2:17 p.m. and 2:43 p.m., the Director of Nursing said that Social Work or nursing should be asking the residents about bathing preferences and frequency. She said the RNM and Social Worker did not have anyone to train them and did not know they should be asking about bathing preferences and frequency. She said the policy revealed that Social Work should be asking about preferences. [10 NYCRR 415.5(b)(3)]	F 561		
F 584 SS=E	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584 Accepted 12/14/18 mo Reviewed by RB	The following was accomplished for the deficiency cited: 1.) A request for service was sent out to one vendor to troubleshoot water temperature issue and provide hot water supply repair on the 78 bed LTC unit which includes Garden View, Orchard View and Canal View. 2.) Vendor confirmed that an on-site service call would be conducted on 11/28/18. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) Water temperature audits were performed by Director of Maintenance on the facility 30 bed dementia unit and 12 bed rehabilitation unit (Autumn View North & South)to ensure separate hot water supply system was within required limits. 2.) The vendor, post service call on 11/28/18, provided a completed service	12/21/2018

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F 584	Continued From page 3 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews conducted during the Recertification Survey, it was determined that for three (Garden View, Canal View, and Autumn View North) of five residential living units, the facility did not maintain a clean, comfortable, and homelike environment. The issues included water not being provided at a temperature comfortable for bathing, a dirty shower chaise, and wall damage. This is evidenced by the following: 1. Observations conducted on 11/9/18 between 10:00 a.m. and 10:24 a.m. included the following: a. In Resident Room 2-B and 3-B (Garden View) there were multiple areas of white paint all around the room and bathroom where patching had been applied but was not repainted. b. There were white patched areas on	F 584	requisition showing the repairs made to the 78 bed LTC unit hot water supply. The following systemic changes have been implemented to ensure continued compliance with this regulation: 1.) All hands-on care staff will be inserviced by the Administrator/designee on the proper procedure for reporting water temperatures that are not within the acceptable temperature range. 2.) Starting 11/28/18, the Director of Maintenance/designee will perform hot water temperature audits 5 days per week on random resident room faucets and shower rooms for the next 2 months. If 100% compliance is achieved in those 2 months, moving forward, audits will be performed on weekly basis. 3.) The random hot water temperature audit results will be reviewed at the monthly QAPI meetings to ensure compliance. The Director of Maintenance will monitor for overall compliance of this plan of correction. _____ _____ The following was accomplished for the deficiency cited: 1.) The Director of Maintenance audited the areas affected to determine the supplies and time needed to fix and/or	

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F 584	Continued From page 4 the walls in Resident Room 31-A (Canal View) that had not been repainted. Review of a "Water Temp Audit," dated 9/11/18 to 10/23/18, revealed water temperatures were taken in one shower room on 9/11/18, 9/13/18, 9/14/18 and 9/18/18 with water temperatures recorded 116 degrees Fahrenheit (*F) to 117*F. 2. Observations and interviews conducted on 11/14/18 between 2:05 p.m. and 2:54 p.m. included the following: a. At 2:05 p.m., the hot water in the bathroom of Resident Room #3 (Garden View) was run for several minutes and never went above 69.6*F. b. At 2:13 p.m., the hot water temperature in the Garden View shower room hand sink was 81*F after being run for more than 20 minutes. The water temperature ranged from 58*F to 92*F and vacillated within that range with the most consistent temperatures ranging 80*F to 81*F. There were quick temperature spikes up and down. c. At 2:15 p.m., Licensed Practical Nurse (LPN) #1 said the shower chaise in the Garden View Shower room needed cleaning. She said the shower chaise is in use and there is at least one person who uses it. LPN #1 said after each use, an aide is supposed to clean it and it should never be left dirty/unclean. LPN #1 donned gloves and lifted the mat and stated that needs to be cleaned. There were webs with dust, dirt and brown colored debris. LPN #1 said the top of the mat looks clean, but it was not lifted for cleaning. LPN #1 said there were concerns with the water being too cool several months ago, but she thought the issue had been	F 584	paint the damaged walls on Canal View, Autumn View North tub room and Laundry service area. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) The Director of Maintenance/designee will repaint all of the walls on Canal View and any other areas found to be in disrepair where patching had been applied but not sealed with paint. 2.) The Director of Maintenance/designee will repair all areas affected and any other areas found to be in disrepair in the Autumn View North tub room 3.) The Director of Maintenance/designee will re-plaster and repaint walls around windows and any other areas found to be in disrepair in Laundry service area. The following systemic changes have been implemented to ensure continued compliance with this regulation: 1.) The Director of Maintenance/designee will conduct monthly environmental audits around facility to ensure walls are in good repair/sealed with paint and tub rooms are in good repair. Any areas found damaged/in disrepair during audits will be repaired in a timely manner. 2.) The environmental audit results will be reviewed at the monthly QAPI meetings to ensure compliance.	

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F 584	Continued From page 5 addressed. LPN #1 added that it takes forever for the water to get warm enough for showering. LPN #1 said sometimes staff run the hand sink water and shower at the same time to try and speed things up. d. At 2:22 p.m., Certified Nursing Assistant (CNA) #1 and CNA #2 said the water takes a long time to get hot enough to use, a good 20 minutes. CNA #1 said she often runs both the hand sink and shower to try and speed up the process. e. At 2:26 p.m, LPN #2 and CNA #1 both said administration is aware of the problem with the water temperatures. LPN #2 said she could not use the shower room that day because of cool water temperatures. CNA #1 said that Resident #62 resides on Garden View and has not been getting showers due to the cool water. f. At 2:40 p.m., Resident #16 said the water is cold and it takes forever to get warm, if it does. Resident #16 said he is told by staff that he can wait until the water gets warm enough or take a shower the following week. He said staff do not offer him a bed bath. He said staff have not offered to take him to another unit for a shower. He said even the water in my bathroom hand sink is cold. At that time, water at the resident's hand sink registered 70*F after several minutes. g. At 2:50 p.m., Resident #23 stated that the problem with the water has been brought up at Resident Council, and they are told that it is set like that for state regulations. The resident stated the water was always cold, and so cold that she cannot wash her hands. She said, "Look at my hair it is dirty. I can not even take a shower because the water is so	F 584	The Director of Maintenance will monitor for overall compliance of this plan of correction.	

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F 584	Continued From page 6 cold." The resident's hair was greasy with numerous specs of white material resembling dandruff. h. At 2:54 p.m., the Director of Maintenance said he was not aware of the current cool water temperatures. He said he had been auditing water temperatures. He said the last audit was conducted September 2018. The Director of Maintenance said administration was aware that Resident Council members had complained of cool water. 3. Observations and interviews conducted on 11/15/18 between 9:20 a.m. and 1:47 p.m. included the following: a. At 9:30 a.m., the water temperature in the Garden View Shower room ranged between 56.9*F and 85.1*F, with a brief spike to 92*F before falling back down. b. At 9:46 a.m., CNA #3 said staff are not always able to use the shower room because the water does not get hot enough. She said staff run the sink water and shower water to try and get it warm enough to give a shower. CNA #3 said facility administration know about this because there was a period of about a week where there was hardly any hot water at all. CNA #3 observed the water temperature in the shower room (83*F) and said it was always cold. d. At 10:19 a.m., LPN #3 said the Orchard unit is his primary unit. He said the shower room water temperature takes a while to get up to temperature, maybe five to ten minutes. e. At 10:57 a.m., Resident #16's family	F 584		

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F 584	Continued From page 7 member said she was on the Family Council and cold-water temperatures had been discussed. She said the council has notified administration, in writing, of their concerns but nothing is ever done. f. At 12:55 p.m. the service area laundry room had large sections of wall damage where the plaster had deteriorated and crumbled around the windows. There were multiple areas above the window frames that were deteriorated and damaged from what appeared to be water leaks. g. At 1:47 p.m., the Autumn View North Unit tubroom had multiple areas of wall damage, wall damage that was patched and not painted, missing cove base, cracked and peeling cove base, and flooring that was peeling near the shower area.	F 584		
F 641 SS=D	[10 NYCRR: 415.29(d)(f)(6)(i)(2)(j)(1)] 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for 3 of 25 residents reviewed for Minimum Data Set (MDS) Assessment accuracy, the facility did not ensure that the MDS Assessments accurately reflected the residents' status. The issues involved inaccurate coding for hospice (Resident #90), inaccurate coding for use of a tube feeding (Resident #94), and inaccurate coding for dental	F 641 Accepted 12/14/18 MO	The following corrective action has been implemented for the deficiency cited: 1)Resident #90 MDS was modified and coded for hospice care, it was submitted and accepted. Resident #94 tube feed MDS has a significant correction on 11/16/18 to the prior comprehensive assessment, and will be care planned and submitted to CMS. Resident #44 MDS for a dental exam, a significant correction to the prior comprehensive assessment was opened on 11/21/18 and is in the process of being completed and care planned. 2)A 100% chart audit was done to ensure residents MDS are being coded correctly for hospice, tube feeds and dental services. 3)Audits will be conducted monthly on all residents with tube feeds, residents on	12/16/2018

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F 641	Continued From page 8 (Resident #44). This is evidenced by the following: 1. Resident #90 was admitted to the facility on 3/16/15 and had diagnoses including dementia without behavioral disturbance, chronic pain, and anxiety. A Hospice Admission Note, dated 9/27/18, revealed the resident was admitted to hospice that date with diagnoses including poorly controlled pain, nausea, and emesis with eating. The Significant Change MDS Assessment, dated 10/6/18, did not include hospice care. Interviews conducted on 11/16/18 included the following: a. At 11:18 a.m., the Director of Nursing (DON) said an outside agency completes the MDS Assessments for the facility. The DON said a Significant Change MDS Assessment had been initiated because of the resident's admission to hospice. She said the MDS Assessment should have been coded for hospice care. b. At 11:30 a.m., a Registered Nurse (RN)/MDS Consultant said the MDS Assessment was inaccurate. She said the resident has been receiving hospice care since 9/27/18, and the MDS Assessment should include hospice care. 2. Resident #94 was readmitted to the facility on 10/1/18 with new diagnoses including intracerebral hemorrhage in the brain stem and the placement of a Percutaneous Endoscopic Gastrotomy (PEG) tube for feeding. The MDS Assessment, dated 10/8/18, did not include a feeding tube.	F 641	Hospice, and all residents with comprehensive assessments for dental for 6 months. Registered Dietician was educated by MDS consultant on accurate coding of MDS for tube feedings. MDS consultant staff have been re-educated on accurate coding of MDS for Hospice and Dental by Manager of Documentation and Staffing at MDS Solutions. 4) The MDS Consultant will provide a monthly report of all resident's on hospice, with feeding tubes, and those who have had dental services for 6 months to the Administrator, who will present this at the monthly QA meeting. The MDS Dept. is responsible for this plan of care and will be monitored by the Administrator.	

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F 641	Continued From page 9 Interviews conducted on 11/16/18 included the following: a. At 11:18 a.m., the DON said the resident was receiving a tube feeding at the time of the MDS Assessment and it should have been coded. b. At 11:30 a.m., a RN/MDS Consultant said the use of a tube feeding should have been coded on the MDS Assessment. 3. Resident #44 was admitted to the facility on 10/18/16 and had diagnoses including dementia with behavioral disturbance, Type 2 diabetes, and congestive heart failure. Review of the Admission Comprehensive MDS Assessment, dated 10/26/16, revealed the resident had obvious or likely cavity or broken natural teeth and inflamed or bleeding gums or loose natural teeth. The Annual Comprehensive MDS Assessment, dated 10/4/17, revealed the resident had no dental issues. The MDS Assessment, dated 9/16/18, revealed the resident had severely impaired cognition and no dental issues. Review of the current Comprehensive Care Plan included that the resident had the potential for oral and dental health problems related to broken natural teeth and/or likely cavities. Review of a Dental Evaluation, dated 10/11/17, included that a root tip was present on the upper right and the resident had several missing teeth. A Dental Evaluation, dated 10/17/18, revealed that the resident refused to open his mouth, and the dentist was unable to examine the resident after multiple attempts.	F 641		

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F 641	Continued From page 10 During an observation on 11/8/18 at 9:40 a.m., the resident had missing teeth and a visibly loose tooth. On 11/14/18 at 9:31 a.m., the resident's lower front tooth was visibly loose and moved when he talked. When interviewed on 11/16/18 at 1:54 p.m., the MDS Consultant stated that an oral assessment was not done when completing the MDS Assessments. She stated that she and her staff would use any dental evaluations in the paper chart to determine the resident's dental status and that information would be used to complete the MDS Assessments. She said that when the MDS Assessment was being completed, it was done after the assessment reference date so her staff would not be doing an oral exam for the resident. [10 NYCRR 415.11(b)]	F 641		
F 656 SS=D	483.21(b)(1) Develop/Implement Comprehensive Care Plan §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;	F 656 Accepted 12/14/18	The following corrective action has been implemented for the deficiency cited: 1) An audit of care plans for resident's # 15,9,104 and 74 on psychotropic medications was conducted by Social Workers to target care plans lacking the medication the resident is prescribed and using, target behaviors and individual interventions/approaches for the resident behaviors. Care plans were updated for medications prescribed, behaviors and approaches and appear on CNA Kardex. An audit was conducted by Nursing of care plan for resident #50 using a CPAP machine. His care plan was updated to include the diagnosis of Obstructive Sleep Apnea and the use of CPAP machine at bedtime.	12/21/2018

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F 656	Continued From page 11 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 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. This REQUIREMENT is not met as evidenced by: Based on interviews and record review conducted during the Recertification Survey, it was determined that for 5 of 25 residents reviewed for care planning, the facility did not develop and implement a plan of care for each resident that included measurable goals and interventions to meet the resident's medical, physical, and nursing needs. The issues involved the lack of a care plan that included target behaviors and individualized approaches for residents receiving psychotropic medications.	F 656	2)A 100% audit of all residents was performed by Social Workers to identify all residents on anti psychotropics. Any residents identified to be using anti psychotropic medication had their care plans updated to include medication prescribed, resident's target behaviors and individual interventions/approaches. An audit was performed to identify all residents using CPAP. All residents identified had their care plan updated to include use of CPAP and diagnosis of obstructive sleep apnea. 3)The Pharmacy Consultant will audit monthly, all residents using anti psychotropic medication. During his monthly audit, nursing & Social Worker will meet with him so they can update/modify any resident care plan that has a anti psychotropic medication added/changed with the behaviors being targeted for the drug use, and individualized interventions that may be instituted for the resident. Nursing/Social Work staff were educated on adding new meds to the care plan when MD writes order, along with behavior being targeted by med and individualized interventions that help control the behavior. Education will be provided to all nursing staff twice a year by the Alzheimer Association to include how to deal with residents with behaviors and person centered approaches/interventions for behaviors. Education on Dementia/Alzheimer Disease will be included in yearly in-servicing and upon hire in orientation. LPN's & RN's have been educated on how to update a care plan when a new antipsychotic drug is added. Every 30 days/monthly Nursing Unit Managers will review all residents using	

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F 656	Continued From page 12 (Resident's #15, #9 and #104), the lack of a care plan for a resident that uses a CPAP (assistive breathing machine that provides continuous positive airway pressure) (Resident #50) and the lack of a care plan for the use of an antipsychotic medication (Resident #74). This is evidenced by, but not limited, to the following: 1. Resident #15 was admitted to the facility on 1/23/17 with diagnoses including dementia with behavioral disturbance, major depressive disorder, and hypertension. The Minimum Data Set (MDS) Assessment, dated 8/14/18, revealed the resident had severely impaired cognition. Review of the current Comprehensive Care Plan (CCP) included that the resident uses Seroquel (an antipsychotic medication) and Depakote (an anticonvulsant medication that is also used to treat behaviors in dementia) and information regarding gradual dose reductions. The CCP or Certified Nursing Assistant (CNA) Kardex did not include target behaviors for the psychotropic medications use, non-pharmacological interventions and/or individualized approaches to address the resident's behaviors. When interviewed on 11/16/18 at 10:52 a.m., CNA #1 stated that she had worked in the facility for two years and had not received any specific training on how to deal with residents with dementia and their behaviors. She said that she gets to know the residents after working with them for so long and figuring out that some things work and other things do not. She stated that the resident can get combative with care, especially when trying to give him a shower, he will yell and try to hit staff. She said sometimes it takes three people to help him, and she will re-approach the resident or get help from the	F 656	CPAP to insure the machine is functional, orders are current, and care plan is updated. CPAP policy was updated to reflect this, and Nursing staff were educated on who to notify should they find a CPAP non-functional. 4)The Social Work Director will present monthly audit data from meeting with Pharmacy Consultant for all residents on psychotropic meds to the monthly QA meeting to include compliance rates for care plans. The Social work audits will continue monthly for 3 months or until 100% compliance is achieved for 2 months. The Nursing Unit Manager will present audits on CPAP machines to the monthly QA meeting to include compliance rates for function of machine and care plans for 3 months or until 100% compliance is achieved for 2 months. The Director of Social Work is responsible for the plan of correction for psychotropic medications and monitored by the Administrator for compliance. The Unit Manager is responsible for the plan of correction for CPAP and monitored by the Director of Nursing for compliance.	

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F 656	Continued From page 13 nurse. She stated the only documention that is on the Care Kardex is to re-approach the resident if he becomes combative with care. CNA #1 said she did not think any other interventions were written down anywhere. When interviewed on 11/16/18 at 11:45 a.m., Licensed Practical Nurse (LPN) #1 stated that it had been a while since the staff had dementia specific training but there was an in-service that is included in the annual mandatory training. LPN #1 said she was not sure if new staff received dementia specific training but added that she provides "on the job" training to new staff helping with strategies to deal with resident's who have dementia. LPN #1 said she was not sure if resident specific behaviors and interventions were on the CCP or Kardex but thought that they should be. She said that the Registered Nurse (RN) is responsible for updating the CCP. She said resident behaviors are discussed during care planning meetings and the CCP would also be updated at that time. In an interview on 11/16/18 at 2:03 p.m., the Director of Nursing (DON) reviewed the resident's CCP and Kardex, and then stated that target behaviors and non-pharmacological interventions were not included in the resident's care plan. She said that there was not enough information included on the CCP and Kardex for a new staff member to know what behaviors the resident had and interventions that were effective. She said that the staff did not have a lot of dementia specific training that year although it has been provided in previous years. 2. Resident #50 was admitted to the facility on 5/14/18 with diagnoses including malignant neoplasm (a disease in which abnormal cells divide uncontrollably and destroy	F 656		

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F 656	Continued From page 14 body tissue) of the kidney, paranoid schizophrenia, and anxiety. The MDS Assessment, dated 9/9/18, revealed the resident was cognitively intact. Physician orders, dated 5/15/18, directed CPAP set at 5 at bedtime. The current CCP did not include the use of a CPAP machine. When interviewed on 11/15/18 at 10:20 a.m., the Registered Nurse Manager (RNM) said that the CPAP should be care planned for and the resident should have a documented diagnosis of Obstructive Sleep Apnea. When interviewed on 11/15/18 at 12:07 p.m., the DON stated that the resident should have a care plan for the CPAP. She said that she completed the initial care plan and did not know the resident had a CPAP. 3. Resident #74 was admitted to the facility on 9/25/17 with diagnoses including chronic obstructive pulmonary disease, myocardial infarction and diabetes mellitus. The MDS Assessment, dated 9/27/18, revealed that the resident was cognitively intact. Progress notes reviewed from 9/1/18 through 11/15/18 did not include the use of the Seroquel (psychotropic medication) or identify any targeted behaviors related to its use. The CCP, dated 9/27/18, did not include the use of a psychotropic medication. When interviewed on 11/16/18 at 12:55 p.m., the DON stated that the use of psychotropic medications should be updated on the care plan by the Social Worker or nursing staff. She said the nursing staff should have updated the	F 656		

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F 656	Continued From page 15 resident's care plan to reflect the use of seroquel. [10 NYCRR 415.11(c)(1)]	F 656		
F 693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #94) of one resident reviewed for feeding tubes, the facility did not have a mechanism in place to ensure that the administration of enteral nutrition and additional water ordered for flushes was	F 693 Accepted 12/14/18 MO	The following corrective action has been implemented for the deficiency cited: 1)The MAR for resident #94 was revised to include a line for each feed administered with a spot to document total feed infused for each feeding. A line was added to document total water flush given with feed. A line was added for total water given with meds. A line was added for total fluids infused in a 24 hour period including prescribed feed and water. The 10p-6a shift LPN is responsible for totaling the feed given in a 24 hour period. 2) A 100% audit of all MAR's for residents on tube feeds was conducted by the Registered Dietician. Those MAR's were updated to include a line for each feed administration and a line for water given with feed for flush and a line for water given with meds and a line to total feed and water administered in a 24 hour period. The following action will be completed to ensure all staff are educated to the correct way to set up a tube feed MAR and the correct way to monitor tube feed via feeding pump: 1)All nurses, LPN & RN, were educated to tube feed policy by the D.O.N./designee, the correct way to set up the MAR and how to total feed and water given in a 24 hour period and how to operate the tube feed pump, including how to clear pump between each feed. 2)The Registered Dietician will audit MAR's of all tube feed resident's weekly, to ensure	12/16/2018

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F 693	Continued From page 16 consistent with and followed physician orders. This is evidenced by the following: The facility policy, "Tube Feed," dated 11/13/18, directs to set the feeding pump for prescribed feeding rate and total volume of feed to be administered and start the feed. Pump is to be cleared and reset after each feeding. When the feed is finished, mark the bottle and or bag at the feed remaining line and initial. Record the total feed milliliters (mls) infused on the Medication Administration Record (MAR) and initial on the MAR at the time of the feed. After the last feed in the 24-hour period, calculate the total daily infusion (amount) and record on the MAR. After all feeds, flush feeding tube with prescribed cubic centimeters (ccs) of water. Resident #94 was readmitted to the facility on 10/1/18 with diagnoses including nontraumatic intracerebral hemorrhage in brain stem with dysphagia (impaired swallowing) and feeding tube placement. The Minimum Data Set Assessment, dated 10/8/18, revealed the resident had moderately impaired cognition. An Enteral Protocol Order Form, dated 10/1/18, included a tube feeding of Jevity 1.2 (a high-protein, fiber-fortified formula) via pump, at 195 mls per hour for eight hours per day, to total 1,560 mls per 24 hours, flush with 75 mls of water before and after each feeding. The total volume of feed and flush is 1,860 mls in 24 hours. The Nutrition Assessment, dated 10/25/18, revealed the resident's estimated calorie needs were 1,540 to 2,310 kilocalories per day and 1,925 to 2,310 mls water per day (based on 25 to 30 mls per kilograms of weight). The current physician orders included Jevity 1.2 set pump to run over a two-hour period at 195	F 693	all tube feed resident's are receiving recommended feed and water and that calculated totals are correct. 3)The unit manager will ensure that all new admissions with a tube feed will have their MAR set up correctly to ensure administration and calculation of all feed and water. This audit will be conducted for 3 months, or until 100% compliance is achieved for 2 months. Audit results will be presented and reviewed at the monthly QA meeting for additional comments or recommendations. 4)Should a resident on a tube feed be given an order for an antibiotic or have a fever, infection or a wound, MD will be contacted for an order for additional water/fluids. The Feeding Tube Policy has been updated to reflect this change in procedure. The Registered Dietician is responsible for this plan of correction and will be monitored by the Administrator.	

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F 693	Continued From page 17 mls an hour, four times a day; and give 75 mls water flush before and after each feeding (which calculates to a total of 2,160 cc of combined water and Jevity in 24 hours) and medication administration. The current Comprehensive Care Plan and Resident Care Card directs to provide tube feed and flushes as ordered by physician. Review of the November 2018 MAR, from 11/1/18 through 11/12/18, revealed an entry for 390 mls Jevity 1.2 four times a day, set pump rate to run over two hours at 195 ml/hour with 75 mls water flush before and after each feeding. Administration times were scheduled for 6:00 a. m., 12:00 p.m., 6:00 p.m., and 12:00 a.m. The nurses have signed each tube feed and flush administration for monitoring, but the MAR does not document the amounts administered to the resident. During an observation on 11/8/18 at 12:40 p.m., the resident was in bed with the tube feeding infusing and the head of the bed was elevated 30 degrees. The bottle of nutrient was labelled Jevity 1.2, with a start date of 11/8/18 (12:00 noon) and the rate was set at 195 mls/hour. The pump was on and the display read infusing at 195 mls per hour, and the amount of tube feed delivered was 512 mls. Observations and interviews conducted on 11/13/18 included the following: a. At 12:50 p.m., a bottle of Jevity 1.2 was infusing, the bottle was dated as hung on 11/13/18 at 5:30 a.m. The pump was on and the display read infusing at 195 ml/hour, and the amount of tube feeding delivered was 535 ml.	F 693		

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F 693	Continued From page 18 b. At 1:24 p.m., the pump alarm sounded and the display read that 626 ml had been delivered. There was a number "157 ml" at the bottom of the screen. When interviewed at that time, LPN #2 said she did not know what that meant. LPN #2 said the tube feeding was set to infuse at 195 mls/hour and it was hung at 5:30 a.m. that morning. LPN #2 said she had turned off the tube feeding that morning, when it stopped and alarmed. She said she started the next feeding around 12 noon that day. c. At 2:31 p.m., a Registered Dietitian (RD) and the surveyor observed the tube feeding set up. The RD reviewed the information written on the nutrient bottle and pump. When interviewed at that time, the RD said there were over 400 mls remaining in the bottle. The RD said the tube feeding had run twice, for a total of four hours and the delivery rate was correct (195 mls/hour). She then said that there should only be 220 mls of tube feeding remaining in the bottle, and it appeared the pump was not delivering the correct amount. The RD said she does not know the facility process to determine accuracy of tube feeding delivery at the end of the day (24 hours) or who is responsible for doing that but she would speak with the nurse about that. When interviewed on 11/14/18 at 10:18 a.m., the Director of Nursing (DON) said she changed the documentation for the resident's tube feeding administration. She said the nurses must reset the pump before each feeding and record the amount of feeding given in that time. The DON said the previous monitoring process did that and she was not sure who or how it was changed. She said that water given with meds and flushes was also to be monitored for volume delivered in a 24-hour period.	F 693		

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F 693	Continued From page 19 In an interview on 11/14/18 at 10:20 a.m., the RD reviewed the November 2018 MAR and said water flushes were not being calculated for volume delivered in a 24-hour period. When interviewed on 11/16/18 at 11:47 a.m., a Licensed Practical Nurse /Rehab Manager said she always transcribes a tube feed order onto the MAR to show the amounts of tube feed nutrient and water given in mls in 24 hours. She said the amounts administered should be documented and calculated separately within the 24-hour period. She said it looked like the process had not been carried over from the previous month and had fallen off the MAR. Additionally, physician orders, dated 11/5/18, directed to give Keflex (antibiotic) 250 milligrams two caps four times a day for ten days and Clindamycin (antibiotic) 150 mgs two caps daily for ten days. When interviewed on 11/16/18 at 10:23 a.m., the RD said the resident was currently receiving 2,175 mls water which is between estimated normal to stress needs of 1,925 to 2,310 mls/day. She said during times of increased stress such as an elevated temperature, infection, or a wound she does not increase the water flush. The RD said fluids are to be encouraged at these times, but the resident was currently unable to take anything by mouth so he cannot be given anything orally. The RD said the resident had been on antibiotics for an infection at the port site. [10 NYCRR 415.12(g)(2)]	F 693		
F 695 SS=D	483.25(i) Respiratory/Tracheostomy Care and Suctioning	F 695	The following corrective action has been implemented for the deficiency cited: 1) Resident #50 medical record was	12/16/2018

Accepted 12/14/18 mo

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F 695	Continued From page 20 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review conducted during the Recertification Survey, it was determined that for one (Resident #50) of one resident reviewed for respiratory care, the facility did not ensure that each resident received necessary respiratory care consistent with professional standards of practice. Specifically, the resident's Continuous Positive Airway machine (CPAP) an assistive breathing machine that provides continuous positive airway pressure) was not maintained or provided as ordered. This is evidenced by the following: Resident #50 was admitted to the facility on 5/14/18 with diagnoses including malignant neoplasm (a disease in which abnormal cells divide uncontrollably and destroy body tissue) of the kidney, paranoid schizophrenia, and anxiety. The Minimum Date Set Assessment, dated 9/9/18, revealed the resident was cognitively intact. Physician orders, dated 5/15/18, directed CPAP (set at 5) at bedtime. The current Comprehensive Care Plan (CCP) did not include the use of CPAP machine	F 695	reviewed and no record/DX of sleep apnea could be located. The group home he had lived in previously was contacted for records and were unable to provide records documenting sleep apnea or when the resident had obtained a CPAP machine. MD wrote an order for a new sleep study. Sleep Insights, a vendor that performs sleep studies was contacted and are currently in process of getting an appointment approved for resident #50. Should the study find resident #50 has a diagnosis of sleep apnea, and needs a CPAP machine, one will be obtained for him. 2) Audit was conducted to identify all resident's in the facility using C-PAP machines. All C-PAP machines identified were checked to insure they were in working order and if not already on plan of care, they were added. 3)All RN & LPN educated on proper functioning of CPAP machine and when to report malfunction. Unit Managers will audit all CPAP machines every Monday to ensure all CPAP machines are functional for 3 months or until 100% compliance is achieved for 2 months. 4)Unit Manager will present audit results at monthly QA meeting for 3 months or until 100% compliance for 2 months The Unit Manager will be responsible for this plan of correction and DON will monitor for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 21 Review of Treatment Administration Records (TARs) included an entry for the CPAP (set at 5) and was scheduled for bedtime daily. a. The June 2018 TAR revealed that the CPAP was not signed off as completed for 10 of 19 opportunities between 6/1/18 and 6/19/18. The nurse initials were circled (meaning the treatment was not completed) beginning 6/20/18 until the end of the month. There was no documentation on the TAR as to why the CPAP treatment was not completed. b. The July 2018 TAR revealed that the nurse's initials were circled seven times for the CPAP and there was no reason documented. c. The August 2018 TAR revealed that the CPAP was not signed off as completed (blank) 20 times and the nurse's initials were circled ten times. Comments on the back of the TAR included the CPAP was not functional, awaiting new mask, and a piece was missing from the CPAP. d. The October 2018 TAR revealed that the CPAP was not signed off as completed 13 times (blank), and the nurse's initials were circled 10 times. Comments on the back of the TAR included the resident refused to wear the CPAP, not worn as it was broken (dropped to floor), and CPAP not worn as it was dropped and needed repair. e. The November 2018 TAR revealed that the CPAP treatment was not signed as completed (blank) 5 of 13 opportunities, and the nurse's initials were circled eight times from 11/1/18 through 11/13/18. Comments on the back of the TAR included the CPAP was not	F 695		

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F 695	Continued From page 22 worn, and the apparatus was broken and nursing was aware. During an observation on 11/13/18 at 11:16 a.m., the CPAP was on the resident's bedside table. When interviewed at that time, the resident stated that he had the CPAP for about a year and that it was supposed to help him breathe better. He said he had not received a new CPAP, had been waiting a month for it, and the company had not been in to see what he needs. When interviewed on 11/13/18 at 2:31 p.m., the resident said he had Obstructive Sleep Apnea and has had it for about five years. He said the CPAP was ok but not great. He said something was wrong with the machine and the mask. The resident said he would try to wear the CPAP again if there was a new one for him. During an interview on 11/14/18 at 2:41 p.m., agency LPN #1 said she had worked at the facility for a couple of months and was familiar with the resident. LPN #1 said that the resident refuses to wear the CPAP. After reviewing documentation on the back of the TAR, the nurse stated that she did not know the CPAP was broken. When interviewed on 11/15/18 at 10:20 a.m., the Registered Nurse Manager (RNM) stated that she thought the CPAP needed another mask, but she did not know the resident had not had his CPAP since June. The RNM said the resident should have had the CPAP repaired sooner. During an interview on 11/15/18 at 11:30 a.m. LPN #2 stated that the resident puts the CPAP on at night and takes it off in the morning. LPN	F 695		

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F 695	Continued From page 23 #2 said she was told by the resident that the mask was not working, a new mask was ordered in September and was received within two days. She said the resident tried on the mask at that time and said it was working. She said she was not aware of any other problems with the CPAP. When interviewed on 11/15/18 at 12:07 p.m., the Director of Nursing (DON) stated that the staff requested a new mask for the CPAP which was provided. The DON said that she was not aware of any further problems with the CPAP machine. [10 NYCRR 415.12 (k)(6)]	F 695		
F 842 SS=D	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842 Accepted 12/14/18 MO	The following corrective action has been implemented for the deficiency cited: 1)The A&I for Resident #17 was reviewed and the effected extremity was reassessed. All pertinent documentation changed to reflect correction. 2)All A&I's for the last 30 days were reviewed to identify any incidents with bruising. Any incident with bruising was reviewed and area of bruising was re-evaluated to insure correct extremity identification. Any issues found with documentation will be corrected. 3)All A&I's with bruising will be validated by ADON/RN designee via visual inspection to ensure proper side (left/right) is recorded on the facility A&I and recorded in the RN assessment documentation. Policy for A&I's was updated to reflect this. Nursing staff were educated on double checking they are recording the correct side of the extremity/body involved. 4)All A&I's with bruising will be reported at monthly QA meeting by the DON/RN designee to reflect the site & extremity for 3 months or 2 months at 100% compliance.	12/21/2018

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F 842	Continued From page 24 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842	The DON is responsible for the prescribed plan of correction.	

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F 842	Continued From page 25 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, conducted during the Recertification Survey, it was determined that for one (Resident #17) of three residents reviewed for injuries of unknown origin, the facility did not maintain medical records on each resident that are accurately documented. The issue included the lack of documention of a bruise on top of the right hand. This is evidenced by the following: Resident #17 was admitted to the facility on 9/11/15 with diagnoses including Type 2 diabetes, heart failure and hypertension. The Minimum Data Set Assessment, dated 8/15/18, revealed the resident had severely impaired cognition, required extensive assistance of two staff for bed mobility, transfer and toileting and extensive assistance of one staff for personal hygiene and locomotion on and off the unit. A review of Progress Notes, from 9/4/18 through 11/14/18, did not reveal documentation of a bruise to the top of the right hand. A Comprehensive Care Plan, dated 9/27/18, included bruising to the left foot and ankle 9/26/18. During observations of personal care on 11/8/18 at 11:03 a.m., and on 11/9/18 at 9:33 a.m., a large purple color bruise was noted to cover the posterior (top) surface of the right hand. A facility Accident and Incident Report, dated 9/11/18, revealed the resident had a bruise on her left hand from a blood draw. The bruise was	F 842		

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F 842	Continued From page 26 greenish purple in color and measured 7.5 centimeters (cm) long by 4 cm wide. Interviews conducted on 11/15/18 included the following: a. At 10:51 a.m., the Director of Nursing (DON) said that she did not have any more Accident and Incident Reports for the resident. b. At 2:03 p.m., a Registered Nurse Manager (RNM) said the bruise was from a blood draw and there should be an Accident and Incident Report. When interviewed on 11/16/18 at 11:59 a.m., LPN #2 said she was the nurse who had reported the bruise to the RNM. LPN #2 said a LPN Manager completed an Accident and Incident Report on 9/11/18 and the RNM had reviewed it and signed it. LPN #2 said it was hard to imagine that three nurses who had looked at the bruise and documented it was on the left hand would be wrong. She said it had to be the left hand. In an interview on 11/16/18 at 3:00 p.m., the DON said she thought that the Accident and Incident Reports could be wrong, and the bruise was incorrectly documented as being on the left hand. [10 NYCRR 415.22(a)(1-2)]	F 842		
F 880 SS=C	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880	The following was accomplished for the deficiency cited: 1.) The Director of Maintenance completed the DOH-5222 form on 12/5/18. 2.) The Director of Maintenance contacted	12/28/2018

Accepted 12/14/18 vso
Reviewed by RB

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F 880	Continued From page 27 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880	current vendor, who tests facility cooling tower for legionella, to draw up a new contract to include a Legionella Management Plan, quarterly domestic water testing cultured by a qualified lab and chemicals & testing for cooling tower & closed loop system. 3.) By 12/28/18, the Director of Maintenance/designee will take water samples, from no less than three separate potable water sources in the facility, and submit them to a certified laboratory for legionella testing. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) Entire facility had potential to be affected by the deficient practice. The following systemic changes have been implemented to ensure continued compliance with this regulation: 1.) The Director of Maintenance will perform quarterly audits of legionella testing vendor paperwork to ensure that quarterly testing was performed on the facility cooling tower, closed loop system and domestic water supply. 2.) The audit results will be reviewed at the QAPI meetings quarterly to ensure compliance. The Director of Maintenance will monitor for overall compliance of this plan of correction.	

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F 880	Continued From page 28 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, an interview, and record reviews conducted during the Recertification Survey, it was determined that for one of one potable water system the facility did not establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection. Specifically, there was no sampling and management program or a risk assessment related to Legionella. The findings are: A review of facility records on 11/15/18 at 2:15 p.m. revealed that the facility had tested their cooling tower for Legionella, but there was no Legionella sampling of the domestic potable	F 880		

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F 880	Continued From page 29 water system. Additionally, there was no documentation that a sampling and management plan, or a risk assessment had been developed related to Legionella. In an interview at that time, the Director of Maintenance stated that they contacted a vendor who is in the process of doing the water management and sampling plans. [42 CFR: 483.80; 10 NYCRR: 415.19; 10 NYCRR: Part 4, Subparts 4-2.3, 4-2.4]	F 880		

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R 814 SS=D	402.7(a)(3)(i) Department Criminal History Review Section 402.7 Department Criminal History Review. (a) After reviewing a criminal history record of an individual who is subject to a criminal history record check pursuant to this Part, the Department and the provider shall take the following actions: ..... (3) Where the criminal history information of a prospective employee reveals a conviction for any crime other than one set forth in paragraph (2) of this subdivision, the Department may, consistent with article 23-A of the Correction Law, propose disapproval of eligibility for employment. (i) The Department shall provide to the provider and the prospective employee, in writing, a summary of the prospective employee ' s criminal history information along with the notification identified in this paragraph. Upon the provider ' s receipt from the Department of a notification of proposed disapproval of eligibility for employment, the provider shall not allow the prospective employee to provide direct care or supervision to patients, residents, or clients of such provider until receipt of a final determination from the Department. This LICENSURE is not met as evidenced by: Based on an interview and record review conducted during the Recertification Survey, it was determined that for one of seven employee files reviewed for the Criminal History Record Check (CHRC), the facility did not immediately remove an employee from duties involving direct	R 814 Accepted 12/14/18 MO	The following corrective action has been implemented for the deficiency cited: 1)The 1 of 7 employees was screened on the nurse aide registry. 2)A 100% audit was completed of all active employees and agency staff files to ensure proper CHRC letters were present. Any areas identified as deficient through the audit were corrected immediately. 3)The HRE was educated, by the Administrator, about the process for new hires who receive 'hold in abeyance' letters from CHRC. The following action will be completed to assure all new hires and agency staff have valid CHRC letters in their files: 1)A monthly audit will be completed by the HRE, of all new employees files, to ensure that a valid CHRC letter is present. The Administrator will complete a monthly review of 2 new employees files to ensure that a valid CHRC letter is present. The results of the monthly audits will be reviewed at the facility QAPI meetings. If 100% compliance is maintained for 3 months, the audit will be completed quarterly for the next three quarters. The HRE will be responsible for the prescribed plan of correction and monitored by the Administrator for compliance.	12/16/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/13/2018

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R 814	Continued From page 1 care and supervision after receipt of a 'hold in abeyance' letter from the CHRC. The findings are: On 11/14/18 from 12:48 p.m. to 1:10 p.m., the Human Resources Employee (HRE) provided the surveyor with seven employee records related to the CHRC. The records showed that an individual began working as a Certified Nursing Assistant (CNA) on 4/10/18 and received a 'hold in abeyance' letter from the CHRC on 4/2/18. The CHRC letter instructed the facility to revoke any temporary approval in a position that involved direct care or supervision to patients. Further review of timesheets for that CNA revealed the person continued to work dozens of shifts between 4/13/18 and 9/18/18, before eventually being cleared through the CHRC on 9/19/18. An interview with the HRE at that time revealed the CNA was hired prior to her beginning work in Human Resources, and that maybe they thought the employee had cleared the CHRC. A review of the facility policy for Criminal Background Check (Item #3a) revealed that when the Human Resource department receives the criminal background check information back from the Department of Health, it will carefully review the information and make a determination as to whether the applicant should be disqualified from employment based on the information provided.' [10 NYCRR Sections 402.7(a)(3)(i), 402.3(i)(1)]	R 814		
I210 SS=C	415.19 Infection Control This LICENSURE is not met as evidenced by: Based on an interview and record review conducted during the Recertification Survey, it	I210	Reviewed by RB accepted 12/14/18 mo The following was accomplished for the deficiency cited: 1.) The Director of Maintenance completed the DOH-5222 form on 12/5/18. 2.) The Director of Maintenance contacted current vendor, who tests facility cooling	12/28/2018

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(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) COMPLETE DATE
I210	Continued From page 2 was determined that for one of one potable water system the facility did not comply with New York State regulations for legionella. Specifically, the facility did not adopt and implement a Legionella culture sampling and management plan by December 1, 2016, did not complete required NYSDOH forms, and did not perform water sampling for legionella every 90 days. The findings include: A review of facility records on 11/15/18 at 2:15 p.m. revealed that the facility had tested their cooling tower for Legionella, but there were no Legionella sampling test results for the domestic potable water system. Additionally, there was no documentation that the facility had completed the DOH-5222 form (Environmental Assessment of Water Systems in Healthcare Settings), nor was there documentation that a sampling and management plan had been developed. In an interview at that time, the Director of Maintenance stated that they contacted a vendor who is in the process of doing the water management and sampling plans. [10 NYCRR: Part 4, Subparts 4-2.3, 4-2.4]	I210	tower for legionella, to draw up a new contract to include a Legionella Management Plan, quarterly domestic water testing cultured by a qualified lab and chemicals & testing for cooling tower & closed loop system. 3.) By 12/28/18, the Director of Maintenance/designee will take water samples, from no less than three separate potable water sources in the facility, and submit them to a certified laboratory for legionella testing. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) Entire facility had potential to be affected by the deficient practice. The following systemic changes have been implemented to ensure continued compliance with this regulation: 1.) The Director of Maintenance will perform quarterly audits of legionella testing vendor paperwork to ensure that quarterly testing was performed on the facility cooling tower, closed loop system and domestic water supply. 2.) The audit results will be reviewed at the QAPI meetings quarterly to ensure compliance. The Director of Maintenance will monitor for overall compliance of this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	11/16/2018

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E 004 SS=C	Develop EP Plan, Review and Update Annually [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a)] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This STANDARD is not met as evidenced by: Based on observations, an interview, and record reviews conducted during the emergency preparedness plan review in conjunction with the Life Safety Code Survey, it was determined that the facility did not comply with emergency	E 004 Reviewed/Accepted by RB 12/17/18 WG	The following was accomplished for the deficiency cited: 1.) The Administrator updated the Emergency Preparedness Plan binders, specifically the facility name, the Mutual Aid Plan (December 2018 copy), the facility name on policies & procedures and the emergency contacts information list for five of five units in the facility. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) The entire facility had potential to be affected by the deficient practice. The following systemic changes have been implemented to ensure continued compliance with this regulation 1.) The Administrator will perform quarterly audits of the Emergency Preparedness Plan binders on five of five facility units to ensure compliance with uniformity of information within the binders. 2.) The audit results will be reviewed at the QAPI meetings quarterly to ensure compliance. The Administrator will monitor for overall compliance of this plan of correction.	12/21/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	12/11/2018

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E 004	Continued From page 1 facility did not fully update the Emergency Preparedness Plan (EPP) annually. The findings are: Observations and record review on 11/15/18 from 10:38 a.m. to 10:53 a.m. revealed the emergency preparedness manuals located on shelves at the Autumn View North and South Unit nurse stations were titled, "Orleans County Nursing Home." The binders also included copies of the Western New York Mutual Aide Plans from 2012/2013, and individual procedures listed for the Orleans County Nursing Home. A page inside each manual (revision date 5/23/11) listed emergency contact information for an Administrator, Director of Nursing, and Director of Maintenance who were no longer employed at the facility. Further review of similar binders located at the centrally located nurse station serving the Garden View, Canal View, and Orchard View Units revealed the same plans with the same dates, and listed the facility as "Orleans County Nursing Home." An interview with the Administrator revealed they have not been affiliated with Orleans County in about three or four years and that the unit EPP binders were probably not updated. [42 CFR: 483.73(a) - Emergency Preparedness]	E 004		
E 036 SS=C	EP Training and Testing (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036	Reviewed & Accepted by KB 12/17/18 mo The following was accomplished for the deficiency cited: 1.) The Administrator developed a facility-wide staff training and testing program for the Emergency Preparedness Plan (EPP), specifically regarding the EPP risk assessment, the EPP communications plan, and the policies and procedures listed in the EPP binder. The following corrective actions have been	12/21/2018

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E 036	Continued From page 2 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on an interview and record review conducted during an Emergency Preparedness review in conjunction with the Life Safety Code Survey, it was determined that the facility did not comply with emergency preparedness requirements. Specifically, the facility did not did not develop a staff training and testing program for Emergency Preparedness. The findings are: On 11/15/18 at 2:15 p.m., the Administrator	E 036	implemented to identify other areas that may have similar potential to be affected: 1.) The entire facility had potential to be affected by the deficient practice The following systemic changes have been implemented to ensure continued compliance with this regulation: 1.) The Administrator will perform quarterly audits of the Emergency Preparedness Plan testing and training documentation to ensure compliance. 2.) The audit results will be reviewed at the QAPI meetings quarterly to ensure compliance. The Administrator will monitor for overall compliance of this plan of correction.	

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E 036	Continued From page 3 stated in an interview that a staff training or orientation Emergency Preparedness Plan (EPP) had not yet been put together. A review of the facility EPP binder provided by the Administrator revealed there was no training and testing program that had been updated on an annual basis. There was no documentation provided by the facility to show that a training and testing program had been developed in conjunction with the EPP risk assessment, the communications plan, and the policies and procedures listed in the EPP binder. [42 CFR 483.73(d) - Emergency Preparedness]	E 036		
E 037 SS=C	EP Training Program (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually.	E 037	Reviewed & Accepted by RN 2/7/18 MA The following was accomplished for the deficiency cited: 1.) The Administrator formulated an Emergency Preparedness Plan (EPP) for the facility. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) All current facility staff, individuals providing onsite services and volunteers will be educated, and a post test given, as it relates to the EPP. The Administrator/designee will be responsible for education and record keeping of attendance/test results for all facility staff. The following systemic changes have been implemented to ensure continued compliance with this regulation: 1.) All new staff will be educated, and a post test given, as it relates to the EPP during new employee orientation. The Administrator/designee will be responsible	12/21/2018

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E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037	for education and record keeping of attendance/test results for all new facility staff. 2.) The Administrator/designee will include EPP training & testing in the facility curriculum of Annual Mandatory Staff in-services. Attendance sheets and test results for these in-services will be maintained in Human Resources for recorded proof of EPP training for all staff. 3.) The Administrator will perform quarterly audits of the Emergency Preparedness Plan training documentation, specifically staff attendance sheets and completed staff testing, to ensure compliance. 4.) These audit results will be reviewed at the QAPI meetings quarterly to ensure compliance. The Administrator will monitor for overall compliance of this plan of correction.	

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E 037	Continued From page 5 arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 6 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on an interview and record review conducted during an Emergency Preparedness review in conjunction with the Life Safety Code Survey, it was determined that the facility did not comply with emergency preparedness requirements. Specifically, the facility did not conduct staff training for all employees on an annual basis. The findings are: On 11/15/18 at 2:15 p.m., the Administrator stated in an interview that they do training for fire emergencies, but there has been no formal Emergency Preparedness Plan (EPP) education or training for all staff. [42 CFR 483.73(d)(1) - Emergency Preparedness]	E 037		

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K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observations, an interview, and record review conducted during the Life Safety Code Survey, it was determined that for one of one automatic extinguishing system, the facility did not properly maintain a sprinkler system. Specifically, a quarterly sprinkler system inspection was missed. The findings are: Observations throughout the facility on 11/13/18 revealed the building is equipped with a full automatic extinguishing (sprinkler) system. Record review on 11/13/18 at 2:10 p.m. revealed there was no inspection report for the sprinkler system between 2/26/18 and 9/19/18. An interview with the Director of Maintenance at that time, revealed he thought the inspection	K 353	The following was accomplished for the deficiency cited: 1.) A request for a scheduled quarterly inspection agreement, for the calendar year 2019, was sent out to facility sprinkler inspection vendor. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) Entire facility had potential to be affected by the deficient practice. 2.) The Director of Maintenance reviewed sprinkler inspection records to ensure that 3rd quarter 2018 inspection was completed. 3.) The Director of Maintenance contacted sprinkler inspection vendor to confirm 4th quarter 2018 inspection had been scheduled appropriately. 4.) The sprinkler inspection vendor completed 4th quarter 2018 inspection on 12/5/18. The following systemic changes have been implemented to ensure continued compliance with this regulation: 1.) The scheduled quarterly sprinkler inspection agreement, for the calendar year 2019, was signed by both parties on 12/7/18 to ensure the four quarterly inspections of facility sprinkler system are completed.	12/18/2018

Reviewed & Accepted by RB 12/7/18 MO

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	12/11/2018

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K 353	Continued From page 1 was done but would have to contact the vendor. There was no documentation provided to show that an inspection of the sprinkler system was performed during the second quarter (April, May, June) of 2018. The 2011 edition of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, requires quarterly inspection and testing of the following water flow and supervisory alarms. [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 101: 19.3.5.1, 9.7.5; 2011 NFPA 25: 5.1.1.2, 5.2.5, 5.3.3.1]	K 353	2.) The Director of Maintenance will provide the 2019 quarterly inspection schedule and completed inspection paperwork audit results for review at the QAPI meetings, quarterly for 1 year, to ensure compliance. The Director of Maintenance will monitor for overall compliance of this plan of correction.	
K 521 SS=E	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on an interview and record review conducted during the Life Safety Code Survey, it was determined that for 10 of 43 dampers the facility did not properly maintain the heating, ventilation, and air conditioning system. Specifically, smoke and fire dampers were not tested. The findings are: During a review of facility records on 11/13/18 at 12:18 p.m. revealed smoke and fire dampers throughout the facility were tested and inspected from 9/5/17 through 9/7/17. Further review of the inspection report revealed 10 of the 43 dampers were not inspected or tested because they require access doors. An interview with the	K 521	The following was accomplished for the deficiency cited: 1.)A request for proposal was sent out to one outside contractor for conducting fire and smoke damper access and inspection services on 10 affected dampers throughout the facility. On 12/4/18, a contract was signed by both parties for completion of the fire and smoke damper access and inspection services on 10 affected dampers throughout the facility. Contractor confirmed they will conduct fire and smoke damper access and inspection services on 10 affected dampers throughout the facility on 12/16/18. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) Entire facility had potential to be affected by the deficient practice	12/16/2018

Returned Accepted by KB 12/17/18 MS

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K 521	Continued From page 2 Director of Maintenance on 11/14/18 at 11:40 a.m. revealed the access doors had not been not installed. The 2010 edition of NFPA 80, Standard for Fire Doors and Other Opening Protectives, requires fire dampers to be tested and inspected one year after installation and every four years thereafter. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in place if so equipped. The 2010 edition of NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives, requires each smoke damper to be tested and inspected one year after installation. The test and inspection frequency shall then be every four years. [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 101: 19.5.2.1, 9.2.1; 2012 NFPA 90A: 5.4.8.1, 5.4.8.2; 2010 NFPA 80: 19.4.1, 19.4.1.1, 19.4.4; 2010 NFPA 105: 6.5.2, 6.5.5]	K 521	2.) The contractor, post access and inspection, will provide to the Director of Maintenance a complete accessible damper inventory list with all 43 locations throughout the facility. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) The Director of Maintenance/designee will schedule a future fire and smoke damper inspection service call for all 43 dampers throughout the facility, not to exceed the first day of August in the year 2021. 2.) The Director of Maintenance/designee will retain a copy of the fire and smoke damper inspection certificate for all 43 dampers throughout the facility. The certificate copy will be located in the facility master QA binder. The certificate will be reviewed in the facility Quality Assurance meetings to ensure compliance. The Director Of Maintenance will monitor for overall compliance of this plan of correction.	
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually	K 918	Reviewed & Accepted by KB 12/17/18 VMS The following was accomplished for the deficiency cited: 1.) On 11/26/18, the Director of Maintenance contacted a vendor to repair generator concerns identified in a 5/1/18 inspection report of the Onan generator. 2.) On 12/7/18 a Purchase Order number	12/18/2018

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(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) COMPLETE DATE
K 918	Continued From page 3 confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observations, an interview, and record reviews conducted during the Life Safety Code Survey, it was determined that for one (100KW Onan Generator) of two emergency generators, the facility did not properly maintain the emergency power supply. Specifically, problems with the generator identified by an inspection were not repaired. The findings are: 1. Observations on 11/13/18 at 2:30 p.m. revealed an Onan GenSet 100KW emergency	K 918	was generated by facility accounts payable department for outside vendor to provide necessary repairs on the Onan generator. 3.) On 12/7/18 the outside vendor confirmed via e-mail that the scheduled repairs for the Onan generator would occur on 12/18/18. The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) The Director of Maintenance checked the Detroit Diesel generator inspection report to ensure there were no concerns or repairs needed. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) The Director of Maintenance will audit all generator inspection and service call reports received for the next 3 months to ensure all generator concerns/problems identified are repaired. 2.) Audit results will be reported by the Director of Maintenance and reviewed in the facility Quality Assurance meetings to ensure compliance. The Director Of Maintenance will monitor for overall compliance of this plan of correction.	

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	335212	A. BUILDING 03 - 2006 BUILDING B. WING _____	11/16/2018

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K 918	Continued From page 4 generator located outside the facility. An interview with the Director of Maintenance at that time revealed the Onan generator supplies emergency power to the older section of the building (Autumn View). 2. On 11/13/18 at 3:00 p.m. inspection and testing records for the emergency generators were reviewed. The records showed that during a routine preventative maintenance inspection on 5/1/18 by an outside vendor, it was identified that the Onan generator had several identified concerns. The report read: radiator has severe leaks, low level fault isn't working, cooling pump bearing is breaking down; and generator should not be running in that manner. In an interview on 11/14/18 at 11:42 a.m., the Director of Maintenance stated that he had checked with the vendor and the items listed had not been repaired and that they would have to contact corporate. The 2010 edition of NFPA 110, Standard for Emergency and Standby Power Systems (EPPS), requires the EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 101: 19.5.1.1, 9.1.3.1; 2010 NFPA 110: 8.3.1]	K 918		
K 921 SS=F	NFPA 101 Electrical Equipment - Testing and Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage	K 921	The following was accomplished for the deficiency cited: 1.) The Director of Maintenance inspected and tested the battery powered sit-to-stand lift labeled 'Canal #3'	12/16/2018

Reviewed & Accepted by RB 12/17/18 mo

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K 921	Continued From page 5 current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is not met as evidenced by: Based on observations, an interview, and record review conducted during the Life Safety Code Survey, it was determined that the facility did not properly inspect and test Patient Care Related Electrical Equipment (PCREE). Specifically, battery powered lifts were not being inspected on a monthly basis per manufacturer's guidelines. The findings are: 1. Observations on 11/13/18 at 10:05 a.m.	K 921	The following corrective actions have been implemented to identify other areas that may have similar potential to be affected: 1.) Maintenance inspection and testing for all battery powered sit-to-stand lifts in facility were completed and documented by Director of Maintenance. The following systemic changes have been implemented to assure continued compliance with this regulation: 1.) The Director of Maintenance will include battery powered sit-to-stand lifts on the list of equipment that will receive a monthly inspection based on the manufacturers specification booklet. 2.) The Director of Maintenance will include battery powered sit-to-stand lift manufacturers specification booklet in the permanent file for service manuals and instructions. 3.)The battery powered sit-to-stand lifts will be added to the electrical inspection log that lists every item of patient care related electrical equipment (PCREE). 4.) The electric inspection log review will be reported on & reviewed in the facility Quality Assurance meetings to ensure that monthly inspections and regular maintenance of battery powered sit-to-stand lifts are being completed. The Administrator/designee will monitor for overall compliance of this plan of	

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K 921	Continued From page 6 revealed an Invacare Reliant RPS 350 sit-to-stand battery powered lift labeled 'Canal #3' located in the corridor between the Garden View and Canal View Units. Further observations revealed similar battery powered lifts on the Autumn View North and South units, and on the Canal View Unit. 2. On 11/15/18 at 10:23 a.m., a manufacturer specification booklet was provided for the 'Sit-to-stand' lifts. The section on maintenance and inspection (page 21) of the manual stated that the lift requires regular maintenance and a monthly institutional maintenance inspection checklist was included. An interview with the Director of Maintenance revealed they look at the lifts, but do not record anything and do not have a list of all the lifts throughout the building. 3. A review of the facility policy on Maintenance of PCREE (including electric portable lifts), dated August 2017, revealed each piece of PCREE will be numbered and a coinciding log sheet per brand/type of equipment will be used to guide inspections/preventative maintenance. The 2012 edition of NFPA 99, Standard for Health Care Facilities, requires facilities to establish policies and protocols for the type of test and intervals of testing for patient care-related electrical equipment. Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment. [10 NYCRR 415.29(a)(2), 711.2(a)(1); 2012 NFPA 99: 10.5.2.1.1, 10.5.3.1.2]	K 921	correction.	

EXHIBIT 30

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F 689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #NY00232714) completed on 4/2/19 the facility did not ensure that each resident receive adequate supervision and assistance devices to prevent accidents for one (Resident #1) of three residents reviewed. Specifically, a resident on aspiration precautions and ordered a pureed diet with honey thick liquids was observed consuming a mechanical soft with thin liquid diet. This also involves Resident #10. The finding is: The policy and procedure entitled "Feeding" dated 6/16 documented facility staff will serve resident trays, will help residents who requires assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. The policy and procedure entitled "Aspiration Precautions" dated 4/5/15 documented when a resident has been identified for being at risk for aspiration, aspiration precautions will be implemented for those residents to reduce the	F 689	The following corrective actions have been implemented for the deficiency cited: A.) Resident #1 was moved to a different table with other resident having the same diet consistency. MD was contacted, informed of wrong consistency consumed and resident #1 was monitored for s/s of aspiration. The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A.) All residents requiring limited assist and supervision for eating along with a pureed consistency and honey thickened liquids were moved to tables with other residents having the same diet. B)Those residents known to grab at other resident trays will be given their trays last, when all staff is present in dining room to monitor that they are not taking other resident food. The following systemic changes have been implemented to ensure continued compliance with this regulation: A.) All nursing staff, including agency staff, will be re-educated on Aspiration Precautions and the difference in diet consistencies by Dietician/designee. B) Seating was rearranged in dining room so like diets all eat together at the same tables.	05/25/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/29/2019

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F 689	Continued From page 1 incidence of aspirations. 1. Resident #1 was admitted into the facility on 9/28/15 with diagnoses of anxiety disorder, dementia without behavioral disturbance and dysphagia (difficulty swallowing). The Minimum Data Set (MDS, a resident assessment tool) dated 12/28/18 documented the resident was cognitively impaired and was sometimes understood and sometimes understands. The current Kardex Report (guide used by staff to provide care) printed 4/2/19 revealed under the resident required limited assist and supervision for eating and was on aspiration precautions. Required a NAS diet with puree consistency and honey thick liquids. A Speech Therapy Plan of Care (Evaluation Only) dated 3/13/19 documented under Precautions: swallowing: puree/ honey liquids, nurse feed only, out of bed all meals in total assist dining room, feed at slow rate only when alert and responsive, utilize utensils, sweep as needed and stop po (by mouth) intake until patient alert/ responsive. Physician Orders dated 3/17/19 documented an order for a NAS (no added salt) diet with puree consistency, honey thick liquids and aspiration precautions. During Lunch meal observation in the assisted dining room on 4/1/19 between 12:05 PM and 12:10 PM, Resident #1 grabbed Resident #10's tray who was sitting directly across from him and ate a ½ (one half) of a tuna sandwich and drank 6 ounces (oz.) of milk and 2 oz. of hot chocolate. Certified Nurse Aide (CNA) #1 walked over to Resident #1 and noticed he had Resident #10's tray and was eating it. At that time, CNA #1	F 689	C) Critical Staffing Policy will be written/instituted to include any other staff that are able to feed residents be present in dining room to assist when staffing is critical. All staff will be educated on this policy by the Department Manager to ensure it is put in place appropriately and all are aware of the role they play in this policy. D)The staffing schedule will be audited every shift x 2 months by unit manager to ensure there is adequate staff to feed meals & monitor dining rooms. If not, Critical Staffing plan will be initiated & DON/ADON will be notified. This audit will be presented in QA monthly to help identify staffing issues by day and shift. E) LPN's, who monitor dining rooms re-educated by DON/designee on importance of staying in dining room to monitor and not leaving the dining room to assist with any other duties. Audit will be conducted by DON/designee x 2 months to ensure dining rooms are adequately monitored. The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 689	Continued From page 2 stated to LPN #1 Resident #1 grabbed Resident #10's tray again and was eating it. CNA #1 took the tray away from Resident #1 and placed it in the cart and re-order another tray for Resident #10. During the observation there was only one Licensed Practical Nurse (LPN) and one CNA in the dining room for at least 45 minutes with a total of 15 residents needing some type of assistance with their meals. Review of a meal ticket for Resident #1 dated Monday Lunch 4/1/19 revealed a NAS (no added salt)- Pureed, "HONEY" thick liquid diet and "ASPIRATION PRECAUTIONS". Review of a meal ticket for Resident #10 dated Monday Lunch 4/1/19 revealed a Regular-Mechanical Soft with thin liquid diet. Review of a Nursing Progress note dated 4/1/19 revealed the resident was noted in dining room at lunch eating from another resident's lunch tray. Resident is a puree diet with honey thick liquids and was noted eating a mechanical soft diet with thin liquids. There were no adverse effects noted, the physician was updated. The writer placed on MAR (medication administration record) to monitor the resident's temperature, lung sounds every shift for three days and update the Registered Nurse (RN)charge nurse or the MD (medical doctor) if any changes were noted. During an interview on 4/1/19 at 12:45 PM, LPN #1 stated, "Resident #1 grabbed Resident #10's tray and began to eat it. This isn't the first time he has done this. He often grabs at things. We put his tray off to the side because he needs to be assisted with his meals as he is on aspiration precautions, and we need to feed him a certain way. I guess we should not put other resident's	F 689		

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F 689	Continued From page 3 trays within his reach or maybe we should move him. I wasn't watching him because I was busy passing other resident's trays because we are short staffed today. We are short staffed today and there was only two of us in the dining room for the majority of the time feeding residents." During an interview on 4/1/19 at 12:55 PM, Supervisor LPN #2 stated, "Resident #1 tends to grab at things. He should have been being monitored in the dining room. I will have staff monitor him for aspiration and will inform the physician of this incidence." During an interview on 4/2/19 at 8:12 AM, the Physician stated, "Resident #1 is on aspiration precautions and he should not have been able to grab that tray. I discussed with staff to possibly moving him in the dining room so that he cannot grab at other residents' trays. I am also going to have Speech Therapy re-evaluate him to possibly increase his diet consistency as he is more awake than he was when he was first evaluated. He is comfort measures and was not really responsive there for a while. I was shocked to hear he did that. I did check him over this morning and he appears to be doing fine and fortunately there was no harm." During an interview on 4/2/19 at 10:32 AM, the Registered Dietitian stated, "Resident #1 should not have been in there without anyone supervising him. He was recently downgraded to the puree honey thick liquids by the Speech Therapist. Aspiration precautions means they should be in an area that is supervised." During an interview on 4/2/19 at 2:00 PM, the Speech Therapist stated, "Resident #1 should be on puree foods with honey thick liquids. I had given staff a set of instructions that were on my	F 689		

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F 689	Continued From page 4 evaluation that they were to follow with this resident. Aspiration precautions means the resident should be out of bed at all meals, sitting upright, no straws, and supervised." 415.12(h)(2)	F 689		
F 725 SS=E	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during an Abbreviated survey	F 725	The following corrective actions have been implemented for the deficiency cited: A.) Resident #1 was moved to a different table with other resident having the same diet consistency. The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A.) All other residents requiring limited assist and supervision for eating along with a pureed consistency and honey thickened liquids were moved to tables with other residents having the same diet. The following systemic changes have been implemented to ensure continued compliance with this regulation: A.) All nursing staff, including agency staff, will be re-educated as to the importance of being seated while feeding residents. B) An audit will be done for 30 days to ensure all staff are seated while feeding residents. The Director of Nursing will be responsible for overall monitoring, evaluation and implementation of this plan.	05/25/2019

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F 725	Continued From page 5 (Complaint #NY00232714) completed on 4/2/19 the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Four (Canal View, Garden View, Orchard View, and Autumn North View) of five resident care units reviewed for sufficient staff did not have adequate staff to meet the needs of the residents. Specifically, the facility lacked sufficient staff on 4/1/19 to ensure showers were provided. This involved Residents #4, 5, 7, 8, 9, 19, 20, 21, 22, 23, 24, 25, 26, 27 and 30. The facility also did not ensure residents were supervised in the assist dining room (#1) and resident's toileting needs were met (#1). In addition, for staff convenience Resident's #1, 2, 3, 4, 7, 10, 11, 12, 13, 14 and 15 for were fed by staff members standing. The findings are but not limited to: Refer to F 689 Free of Accident Hazards/ Supervision/ Devices - Scope and Severity (S/S) = D The "Facility Assessment Tool" completed by the Administrator, Director of Nursing (DON), Governing Body Rep, and Medical Director and reviewed on 11/16/17 and 12/6/18 documented the facility's Staffing plan was to ensure sufficient staff to meet the needs of the residents at any given time. Staffing based on census fluctuation is minimal because average census is 110-118 per diem. RN's & LPN's (registered nurses and licensed practical nurses) providing direct care:	F 725	_____ The following corrective actions have been implemented for the deficiency cited: A.)Nursing staff ensured that Residents # 4,5,7,8,9,19,21,22,23,24,25,26,27 and 30 were given showers to make up for the ones missed. The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A.) Staffing schedules were reviewed for the next month to ensure staffing levels were met based on the Facility Assessment. For any days that were not met - the HR Scheduling Coordinator asked staff who were off, staffing agencies and staff on other shifts to pick up hours of work. B) Resident baths/showers will be placed on 24 hour report sheet; unit LPN will document on 24 hour report sheet if bath given. 24 hour report sheet will be audited by DON/designee daily and missed/refused bathing will be communicated to RN manager in morning report for staff to make up that day. The following systemic changes have been implemented to ensure continued compliance with this regulation: A.) The Administrator will put a Staffing policy into place, that will include a critical and minimal staffing component, and educate managers, charge staff and HR	

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F 725	Continued From page 6 - 1 Director of Nurses (DON): full-time Days; RN - Assistant DON: full-time days, RN - Registered Nurse (RN) or Licensed Practical Nurse (LPN) Charge Nurse: 1 for each shift (Days, Evenings and Nights) - 5 LPN's on Days and Evening- 1 per unit (AVN (Autumn View North), AVS (Autumn View South), CV (Canal View), OV (Orchard View), GV (Garden View)) - 4 LPN's on Nights (unit coverage varies) Direct care staff: - 10 CNA's (certified nurse aide) Days and Evenings (1 on AVS, 3 on AVN-can flex if necessary) - 6 CNA's Nights- 1 per unit, 2 on AVN Review of "(Name of facility) Suggested Staffing" dated 1/28/19 revealed the following: - 1 RN on Days, Evening & Nights - 2 Unit Managers on Days, None on evenings & Nights - 5 LPN's on Days, Evenings & Nights - 12 CNA's on Days & Evenings, 8 on Nights Review of the "Report of Nursing Staff Directly Responsible for Resident Care Sheet" dated 4/1/19 revealed there was 1 RN on days (6:00 AM - 2:00 PM); 6 LPNs on days, 7 LPNs on evenings (2:00 PM - 10:00 PM) and 4 LPNs on nights (10:00 PM - 6:00 AM); 6 CNAs on days, 10 CNAs on evenings and 3 on nights with a total census of 112 residents at the start of day and evening shift and 115 at nights. Review of "Daily Census" dated 3/31/19 and printed on 4/1/19 revealed the total active census was 115 and the following census per unit: Orchard View 22 residents; Garden View 24 residents; Canal View 27 residents; Autumn	F 725	Scheduling Coordinator on the policy. B.) An audit will be completed by the Administrator daily to confirm staff levels are met & if not, critical staffing protocol will be put into place. The Administrator will present these findings at monthly QA. C)HR/scheduler was re-educated on facility assessment standards. Schedules will be reviewed daily by Administrator and PTO requests reviewed by DON/designee to ensure adequate staffing prior to PTO approval. The Administrator will be responsible for overall monitoring, evaluation and implementation of this plan.	

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	335212	A. BUILDING _____ B. WING _____	04/02/2019

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F 725	Continued From page 7 View North 12 residents; and Autumn View South 30 residents. 1. Resident #1 was admitted into the facility on 9/28/15 with diagnoses of anxiety disorder, dementia without behavioral disturbance and dysphagia (difficulty swallowing). The Minimum Data Set (MDS, a resident assessment tool) dated 12/28/18 documented the resident was cognitively impaired and was sometimes understood and sometimes understands. The current Kardex Report (guide used by staff to provide care) printed 4/2/19 revealed under the resident required limited assist and supervision for eating and was on aspiration precautions. Required a NAS (no added salt) diet with a pureed consistency and honey thick liquids. During Lunch meal observation in the assisted dining room on 4/1/19 between 12:05 PM and 12:10 PM, Resident #1 grabbed Resident #10's tray who was sitting directly across from him and ate a ½ (one half) of a tuna sandwich and drank 6 ounces (oz.) of milk and 2 oz. of hot chocolate. CNA#1 walked over to Resident #1 and noticed he had Resident #10's tray and was eating it. CNA #1 stated to LPN #1 that Resident #1 grabbed Resident #10's tray again and was eating it. CNA #1 took the tray away and placed it in the cart, and re-order another tray for Resident #10. In addition, during the entire meal LPN #1 was standing and walking around feeding five to six residents at a time. LPN #1 was moving from one resident to another while giving each a couple spoonful of food before moving to the next resident. This included Residents # 1, 2, 3, 4, 7, 10, 11, 12, 13, 14 and 15.	F 725		

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F 725	Continued From page 8 During this observation there was only one LPN and one CNA in the dining room for at least 45 minutes with a total of 15 residents needing some type of assistance with their meals. Review of a meal ticket for Resident #1 dated Monday Lunch 4/1/19 revealed a NAS (no added salt)- Pureed, "HONEY" thick liquid diet and "ASPIRATION PRECAUTIONS". Review of a meal ticket for Resident #10 dated Monday Lunch 4/1/19 revealed a Regular-Mechanical Soft with thin liquid diet. During an interview on 4/1/19 at 12:45 PM, LPN #1 stated, "Resident #1 grabbed Resident #10's tray and began to eat it. This isn't the first time he has done this. He often grabs at things. We put his tray off to the side because he needs to be assisted with his meals as he is aspiration precautions and we need to feed him a certain way. I guess we should not put other resident's tray within his reach or maybe we should move him. I wasn't watching him because I was busy passing other resident's trays because we are short staffed today. The reason I was standing through the entire meal was because I had five to six residents to feed. It is easy for me to walk around and help the residents instead of rolling around sitting on a chair. We are short staffed today and there was only two of us in the dining room for the majority of the time feeding residents. I know I should not have been standing." During an interview on 4/1/19 at 12:55 PM, Supervisor LPN #2 stated, "Resident #1 tends to grab at things. He should have been being monitored in the dining room. Staff should be sitting while feeding residents. I can see why staff wasn't sitting though as we are short staffed	F 725		

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F 725	Continued From page 9 today. It is pretty regular that we are short staffed. The CNAs were not able to get their showers done this morning because there is only one CNA on each unit." Review of Bath/ Shower Schedule for Mondays revealed the following for each unit: - Canal View- Resident # 4, 5, 22, and 23 were scheduled to be showered - Garden View- Resident # 8, 9 and 21 were scheduled to be showered - Orchard View- Resident #7, 19, and 20 were scheduled to be showered - Autumn View North- Resident # 24, 25, 26, 27 and 30 were scheduled to be showered During an interview on 4/1/19 at 1:50 PM, CNA #1 stated, "I worked on Canal View today and I did not get any of my showers done. There were four Residents that didn't receive them. I worked as hard as I could, but I just could not do the showers. I was the only CNA over there, we were short staffed. We are short staffed a lot of the times." During an interview on 4/1/19 at 1:58 PM, CNA #4 stated, "I am the only CNA on Orchard View today. I was not able to get the showers done today. I had three residents scheduled to have showers done today. We are short staffed today. Also, I was not able to toilet Resident #1 every two to three hours today and I just got to him and he was incontinent. Normally if I am able to toilet him as scheduled he is not incontinent." During an interview on 4/1/19 at 1:59 PM, CNA #2 stated, "I was not able to complete any of my showers today on Garden View. There were three residents scheduled to be showered, that I was not able to get done. Residents' hair didn't	F 725		

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F 725	Continued From page 10 get done either. I was the only aide over there, we are very short staffed today. I had my nurse help me with the two assists. We are short staffed quite often." During an interview on 4/1/19 at 2:10 PM, CNA #3 stated, "I was not able to get all my work done today because we were short staffed. I was not able to get any of my showers done today. I had five showers scheduled for today. There are thirty residents for only two aides and five showers over here on Autumn View North today. I didn't even take a lunch today. They are normally short staffed. Sometimes we have two CNAs on each unit and on a rare occasion three. When we have three aides, those are the days we will do nails and hair." During an interview on 4/2/19 at 10:55 AM, Resident #5 stated, "I did not get my shower yesterday. I mind that I did not get it because of cleanliness." The resident had an odor to him and his hair was uncombed and greasy. During an interview on 4/2/19 at 11:07 AM, Resident #4 stated, "No I did not get my shower yesterday because they were short staffed. I like to get my shower once a week because I like to be clean." The resident had a pungent odor to her. During an interview on 4/2/19 at 11:13 AM, Resident #8 stated, "No I did not get my shower yesterday. I just washed myself up in the sink." During an interview on 4/2/19 at 11:15 AM, Resident #7 stated, "I did not receive my shower yesterday. Yes, it bothered me. I like to be clean." During an interview on 4/2/19 at 11:20 AM,	F 725		

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F 725	Continued From page 11 Resident #9 stated, "No I did not receive my shower yesterday. Staff was too busy." Review of Daily Staffing Worksheets from March 1, 2019 through March 31, 2019 revealed the staffing levels from the Facility Assessment was not met for the following: - The number of CNAs needed for the Day shift, were not met for eight out of the 31 days. Evening shift CNA levels were not met for six out of 31 days, and the Night shift CNA staffing levels were not met for 19 out of the 31 days. - The number of LPNs needed for the Day and Evening shifts were not met for two out of the 31 days and LPN Night shift staffing levels were not met 14 out of the 31 days. During an interview on 4/2/19 at 11:35 AM, the Human Resources/ Scheduling Coordinator stated, "the minimum requirements I follow when trying to staff are 13 CNAs for days and evenings and 7 for overnight; 6 or 7 LPNs for days and evenings and 4 for overnight. I do have sheets that I go by. It was actually developed by a consultant that we had in here at one point. This suggested staffing level was discussed at a meeting with the consultant, the Administrator, DON and me. It was agreed upon that we would try to follow it. If I do not have enough staff I will reach out to staff that are off and agencies to fill the positions needed. I have told the Administrator when we are short staffed. If staffing is at a minimal I believe the Administrator has a "all hands-on deck plan." "Corporate currently has staff coming in from all over the United States. They will put up CNAs and LPNs to help out. It is sometimes very difficult and challenging to get all the staff we need."	F 725		

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F 725	Continued From page 12 During an interview on 4/2/19 at 1:44 PM, with the Administrator and the DON it was stated that the facility staffs by what is on the Facility Assessment. It was stated that the Facility Assessment was their "optimal" staffing schedule, not minimal. When asked what their minimal staffing was nothing was provided or stated. It was stated that the facility did have a consultant in there, not just for staffing though. The consultant did have a suggested staff schedule and that they did discuss using it. The Administrator stated they did not have a policy for staffing yet and that they have one in draft form only. When staffing is at critical levels the Administrator stated they would enlist the help of the department managers to help do what they can. 415.13(a)(1)(i-ii)	F 725		

EXHIBIT 31

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F 725 SS=D	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Compliant #NY00233490) completed on 7/9/19, the facility did not have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental and psycho-social	F 725	The following corrective actions have been implemented for the deficiency cited: A.) No residents were found to have been affected by the deficient practice. The following corrective actions have been implemented to identify other areas that have the potential to be affected by this same practice: A.) Staffing schedules were reviewed for the next month to ensure staffing levels were met based on the Facility Assessment. For any days that were not met - the HR Scheduling Coordinator asked staff who were off, staffing agencies and staff on other shifts to pick up hours of work. The following systemic changes have been implemented to ensure continued compliance with this regulation: A.) The Administrator put a Critical Staffing Policy into place in May 2019, that includes a critical and master staffing component. The master staffing plan is developed to meet the daily needs of the residents and provide quality care within acceptable standards of practice. The Administrator is responsible for enforcing a plan whereby all departments support resident care when critical staffing levels occur. The Administrator will re-educate managers, charge staff and HR Scheduling Coordinator on the policy. B.) The Villages has increased the pay scale for CNAs and nurses based on years	08/16/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	08/09/2019

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F 725	Continued From page 1 well-being of each resident. Specifically, the facility did not meet the minimum standards they set for nursing staff as documented in the Facility Assessment Tool; and did not meet the minimum standards set for certified nurse aides (CNA) as documented in the facility Critical Staffing Plan. The findings are: Review of the Facility Assessment Tool dated reviewed on 11/16/17 and 12/6/18 documented the facility has 120 licensed beds including 12 short-term rehab (rehabilitation) beds, 30 locked dementia beds and 78 long term care beds: Garden view 27 total beds, Orchard view 24 total beds and Canal view 27 total beds. The average daily census is 113. General staffing for nurses is a Registered Nurse (RN), Director of Nursing (DON) and an RN Assistant DON (ADON). An RN or Licensed Practical Nurse (LPN) Charge Nurse 1 for each shift, 5 LPN's on days and evenings - 1 per unit, and 4 LPN's on nights (unit coverage varies). Review of an Approved Plan of Correction for F 725 scope and severity D cited during an Abbreviated survey dated 4/2/19 documented the Administrator will put a staffing policy into place, that includes a critical and minimal staffing component and educate managers, charge staff and the Human Resources Scheduling Coordinator on the policy. Review of the Critical Staffing Plan dated 5/2019 revealed the master staffing plan for CNAs is developed to meet the daily needs of the residents and provide quality care within acceptable standards of practice. The Administrator is responsible for enforcing a plan whereby all departments support resident care	F 725	of experience. Ads for nursing are in the local media (Orleans County Penny Saver and Orleans Hub.com) and online (Indeed.com). Shift differentials are in place for 2p-10p and 10p-6a shifts. An outside agency currently has a class of 9 CNAs being trained and will look to place them at The Villages upon passing exams and certification in late August 2019. The Villages will continue hiring traveling nurses and CNAs through our relocation program from other states. The Villages recently instituted a weekend pickup bonus for aides and nurses who pick up full or half shifts. C.) An audit will be completed by the Administrator daily to confirm staff levels are met & if not, critical staffing protocol will be put into place. The Administrator will present these findings at monthly QA. C)HR/scheduler and Director of Nursing were re-educated on facility assessment standards. Schedules will be reviewed daily by Administrator and PTO requests reviewed by DON/designee to ensure adequate staffing prior to PTO approval. The Administrator will be responsible for overall monitoring, evaluation and implementation of this plan.	

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F 725	Continued From page 2 when critical staffing levels occur. The CNA Staffing Master Plan documented the following: -Day shift (6:00 AM to 2:00 PM). Total of 10 CNAs. Short-term rehab (Autumn South) 1 CNA; dementia unit (Autumn North) 3 CNAs; Garden view 2 CNAs; Orchard view 2 CNA and Canal view 2 CNAs. Critical level 5 CNAs with 0 on rehabilitation, 2 on dementia and 1 each on Garden view, Orchard and Canal view. -Evening shift (2:00 PM to 10:00 PM) Total of 10 CNAs same as day shift with Critical Level at 5. -Night shift (10:00 PM to 6:00 AM) Total of 6 CNAs with Critical level at 3 Review of staffing "Worksheets" for June and July 2019 revealed the following: Saturday 6/9/19 Census 114 (residents). Rehab 12, Dementia 30, Garden view 26, Orchard view 23, and Canal view 23. -Day shift (6:00 AM to 2:00 PM): Total 8 CNAs: Dementia - 2 CNAs. 1 started at 7:45 AM. Orchard view - 2 CNAs. 1 started at 11:30 AM. -Evening shift; Total 3 LPN's. 1 LPN covered dementia, rehab unit and was the building supervisor. 1 LPN covered 2 units Orchard and Canal view. -Night shift: Total 2 CNAs and 4 LPNs. The LPN building supervisor covered Canal view. Saturday 6/15/19 Census 110. Rehab 10, Dementia 29, Garden view 24, Orchard view 23, Canal view 24. -Night shift: Total 4 LPNs. 1 LPN covered Canal and Garden view. 1 LPN covered Orchard and view was the building supervisor. 1 LPN on rehab unit also acted as the CNA. Total 3 CNAs.	F 725		

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F 725	Continued From page 3 The CNA on Orchard view and the CNA on Garden view split the assignment on Canal view. Saturday 6/22/19 Census 108. Rehab 8, Dementia 30, Garden view 24, Orchard view 22, Canal view 24. -Night shift: Total 4 LPNs. The LPN building supervisor covered Orchard and Canal view. 1 LPN worked until 2:00 AM leaving 3 LPNs. Total 4 CNAs. 1 CNA covered the dementia and rehab unit. Sunday 6/23/19 Census 108. Rehab 8, Dementia 30, Garden view 24, Orchard view 22, Canal view 24. -Evening shift: Total 4 LPNs. The LPN building supervisor covered the dementia and rehab units. Rehab unit had 2 CNAs. Garden View had 1 CNA. -Night shift: Total 3 LPNs. The LPN building supervisor covered Orchard view and acted as the CNA on Canal view. Total 4 CNAs. With the LPN covering as an CNA on Canal view, each unit had 1 CNA. Saturday 6/29/19 Census 110. Rehab 10, Dementia 30, Garden view 23, Orchard view 22, Canal view 24. -Night shift: Total 4 LPNs. The LPN building supervisor covered Orchard view. 1 LPN covered the dementia and rehab unit. There was 1 CNA on each unit. Sunday 6/30/19 Census 109. Rehab 10, Dementia 29, Garden view 23, Orchard view 22, Canal view 24. -Evening shift: Total 3 LPNs. The LPN building supervisor covered Orchard and Canal view. 1 LPN on rehab. 1 LPN on dementia unit. -Night shift: Two LPNs for the building.	F 725		

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F 725	Continued From page 4 Saturday 7/6/19 Census 104. Rehab 6, Dementia 29, Garden view 23, Orchard view 22, Canal view 24. -Evening shift: Total 4 LPNs. The LPN building supervisor covered Canal view and Garden view. -Night shift: Total 4 LPNs. 1 LPN did not start until 3:30 AM. Sunday 7/7/19 Census - 104. Rehab 6, Dementia 29, Garden view23, Orchard view 22, Canal view 24. -Evening shift: Total 3 LPNs. The LPN building supervisor covered Orchard view and Canal view. -Night shift: Total 3 LPNs. The LPN building supervisor covered Orchard view and Canal view. Interview on 6/27/19 at 2:30 PM with the Human Resources/ Scheduling Coordinator revealed there had been "a lot of time and effort" trying to hire staff. The nurses are given bonuses for signing on and for working extra shifts. The facility does use several temporary agencies to fill the schedule. She stated, "I was a CNA and tried to help by filling in at times." Interview with the DON on 6/27/19 at 2:35 PM revealed "corporate" had recently increased the pay scale for CNAs and nurses. Ads for staff are in all the local media and online, but they have few applicants. Shift differentials and salaries were recently increased but it is very difficult to get staff especially RN's. An outside agency currently has a class of CNAs being trained and she hoped the students that pass the exam will stay on as staff. A second class will start in August. They use traveling nurses and CNAs to fill the schedule because of the difficulty finding staff to hire. One problem is staff calling in on	F 725		

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	336212	A. BUILDING _____ B. WING _____	07/09/2019

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

(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) COMPLETE DATE
F 725	Continued From page 5 the day scheduled or not showing up for work at all. Interview with the DON on 7/9/19 at 3:00 PM revealed when there is a shortage of staff, employees from other departments will come in and help as needed. "It wasn't for lack of trying to hire staff but the fact that they don't receive many applicants." Interview with the Administrator on 6/27/19 at 2:40 PM revealed he is aware of the shortage of staff and bonuses for signing on and for taking extra shifts were offered. He stated it was difficult to find and retain the staff once hired. 415.13(a)(1)(i-ii)	F 725		

EXHIBIT 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS A COVID-19 Focus Survey, ACTS reference #NY00256514, was conducted at The Villages of Orleans Health and Rehabilitation Center on 5/9/20 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During this survey it was determined the facility was in Immediate Jeopardy, effective 5/9/20, under the requirements of 42 CFR 483.80 Infection Control, F880. The facility failed to protect asymptomatic non-COVID-19 residents. Certified Nurse Aides (CNA) and Licensed Practical Nurses (LPN)) entered and exited the room of a resident diagnosed positive with COVID-19 who was on Standard and Droplet precautions passed breakfast trays, assisted the resident with their meal and provided hands on care without wearing PPE. 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 presumed COVID-19 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. The Regional Administrator (covering for the facility Administrator) was informed of the Immediate Jeopardy and provided the Immediate Jeopardy Template on 5/9/20. On 5/14/20 and 5/18/20 the Facility submitted	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	05/29/2020

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F 000	Continued From page 1 allegation letters for the Removal of the Immediate Jeopardy. On 5/18/20, a Second Post-Survey Revisit was conducted, and it was verified that the facility re-educated their staff on the use of PPE and hand hygiene. Residents have been cohorted to their respective status and new signage coding has been posted on the doors. A monitoring system has been implemented. There is Epidemiology involement and negative residents are being moved to other facilities. As a result of this survey, it was determined the Immediate Jeopardy for F880 was abated as of 5/18/20. The facility remains out of compliance for the deficiency cited under the following requirement for Long Term Care Facilities: 42 CFR 483.80 Infection Control	F 000		
F 580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580	I. The following actions were accomplished for the residents identified in the sample: Resident #1 • The resident's representative was notified of the resident's change in condition that began on 5/8/20, that COVID-19 testing was performed on 5/6/20 and 5/8/20 and the results of these tests and this is documented in the nursing progress note on 5/10/20. • The physician's orders and test results have been placed in the medical record for the COVID-19 tests obtained on 5/6/20 and 5/8/20. II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:	06/15/2020

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F 580	Continued From page 2 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during a COVID-19 Infection Control Focus Survey (Complaint #NY00256514) 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	F 580	All residents have the potential to be affected by this practice: A. All medical records have been reviewed to ensure resident representatives were notified if there was a new onset of COVID-19 symptoms, if a COVID-19 test was obtained and lab results for all completed COVID-19 tests. III. The following system changes will be implemented to assure continuing compliance with regulations: B. The "Resident Change in Condition" policy and procedure was reviewed without revision. o The Director of Nursing and all LPNs/RNs will be re-educated on their responsibility to notify the resident's designated representative timely of changes in the resident's condition with emphasis on new onset of COVID-19 symptoms (i.e., fever, loss of appetite, lethargy, etc.) and change in treatment plans (i.e., COVID-19 testing) C. The "COVID-19" policy was reviewed without revision. o All LPNs/RNs will be re-educated on their responsibility to obtain a physician's order for COVID-19 testing. D. A written post-test will be administered after the above training to substantiate that learning has occurred. E. All training components have been added to initial and annual orientation. IV. The facility's compliance will be monitored utilizing the following quality assurance system:	

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F 580	Continued From page 3 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 which included dementia, unspecified cerebrovascular disease, history of malignant neoplasm. 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	F 580	A. The Director of Nursing/Designee will review all Nursing Progress Notes for three (3) months to ensure timely notification of resident representatives when there is a new onset of COVID-19 symptoms or a change to the treatment plan to requires COVID-19 testing. B. Nurse Managers/Designee will audit all COVID-19 lab reports to ensure there is a physician order and the results are available in the medical record. C. Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results. Responsibility: Director of Nursing	

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F 580	Continued From page 4 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 Tylenol 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 (MAR) dated 5/1/20 through 5/31/20 revealed Resident #1's temperatures were monitored and were as follows: 5/7/20 night shift- 100 ° 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	F 580		

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F 580	Continued From page 5 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.	F 580		

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F 580	Continued From page 6 415.3(e)(2)(ii)(b)(c)	F 580		
F 880 SS=K	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based	F 880	I. The following actions were accomplished for the residents identified in the sample: A. All resident units will be cleaned with an EPA approved environmental cleaning chemical fogger. B. Resident room assignments have been reviewed and changes appropriately made to cohort COVID-19 positive residents and those who are symptomatic to the designated locations within the facility. C. Ambulatory residents who are currently COVID-19 positive, or suspect COVID-19, will be instructed to remain in their rooms with the doors closed. They have also been provided facemasks and instructed to wear them if it becomes necessary to exit their rooms. D. Contract/Droplet precautions have been implemented and signage is in place for those residents who are under investigation (symptomatic) for COVID-19. E. All clean linen carts have been covered. F. All staff identified have been provided appropriate PPE and received education on proper use and required hand hygiene prior to entering or exiting a resident's room or having resident contact. G. CNA #3 is out on sick leave due to COVID-19 and will be re-educated on placement of his facemask to cover his nose and mouth upon return. H. Unit PPE bins and storage areas have been stocked with PPE including gowns, masks, gloves & goggles/face	06/15/2020

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F 880	Continued From page 7 precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during the COVID-19 Infection Control Focus Survey (Complaint #NY00256514) 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	F 880	shields. I. All supervisors have been given access to and educated on PPE storage area location and process to be used if additional supplies are needed. II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice: All residents have the potential to be affected by this practice: A. All resident units will be cleaned with an EPA approved environmental cleaning chemical fogger. B. Resident room assignments have been reviewed and changes appropriately made to cohort COVID-19 positive residents and those who are symptomatic to the designated locations within the facility. C. Ambulatory residents who are currently COVID-19 positive, or suspect COVID-19, have been instructed to remain in their rooms with the doors closed. They have also been provided facemasks and instructed to wear them if it becomes necessary to exit their rooms. D. Contact/Droplet precautions have been implemented and signage is in place for those residents who are under investigation (symptomatic) for COVID-19. E. All clean linen carts have been covered. F. All staff have been provided appropriate PPE and received education on proper use (including proper placement of face masks covering the nose and mouth) and required hand hygiene prior to exiting a resident's room or having resident contact.	

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F 880	Continued From page 8 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 COVID-19 who was on Standard and Droplet precautions passed breakfast trays, assisted the resident with their meal and provided hands on care without wearing PPE (personal protective equipment). 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	F 880	G. Unit PPE bins and storage areas have been stocked with PPE including gowns, masks, gloves & goggles/face shields. H. All supervisors have been given access to and educated on PPE storage area location and process to be used if additional supplies are needed. III. The following system changes will be implemented to assure continuing compliance with regulations: As per the Directed Plan of Correction, the Consultant has developed and implemented an In-service Program to address the below: A. The facility has purchased an EPA approved environmental cleaning chemical fogger (Vital Oxide Disinfectant Cleaner) and all resident units will be treated. B. The facilities "Donning/Doffing PPE", "Contact/Droplet Precautions" and "Hand Hygiene" policies have been reviewed without revision. All staff will be re-educated on these policies with emphasis on: o Proper positioning of face masks to completely cover mouth and nose. o Proper donning/doffing of PPE followed by hand hygiene prior to exiting an isolation room or resident contact. C. The facilities "COVID-19" policy has been reviewed and revised to include: o Immediate Contact/Droplet isolation of residents with new onset of COVID-19 symptoms, including closed doors & signage, and relocation to the facility designated area for residents under	

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F 880	Continued From page 9 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 COVID-19 delivering meal trays and providing set up assist to the residents. During observations on 5/9/20 at 8:14 AM LPN #2 delivered a breakfast tray to an actively coughing resident diagnosed with COVID-19 provided meal set up while wearing a uniform and a face mask that covered the nose and mouth. 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	F 880	suspicion. o Limited access to common areas for all residents that are COVID-19 positive or suspect to be positive and use of face mask during transport or when room isolation is not feasible. o Ensuring there is frequent monitoring throughout each shift to ensure availability of PPE. o All staff will be re-educated on these policy updates. D. The facilities "Standard Precautions/Linen Handling" policy has been reviewed without revision. All RNs/LPNs/CNAs will be re-educated on this policy with emphasis on covering linen while parked in care areas. E. The "Agency Nursing Service Orientation" policy has been reviewed and revised to include a review of the facility's Infection Prevention & Control program and the training program developed per this directed plan of correction when reporting for their first shift. The DON and Staffing Coordinator have been educated on this policy update. F. A written post-test will be administered after the above training to substantiate that learning has occurred. G. All training components have been added to initial and annual orientation. IV. The facility's compliance will be monitored utilizing the following quality assurance system: As per the Directed Plan of Correction, a QA&A Committee meeting was held on 5/27/20 to examine this deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	05/09/2020

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

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F 880	Continued From page 10 assisted the COVID-19 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 COVID-19 providing meal set up while wearing a uniform, a face mask that covered the nose and mouth, and gloves. 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	F 880	A. The Director of Nursing/Designee and off-shift Supervisors will conduct ten (10) random audits weekly for four (4) weeks and then monthly for two (2) months to ensure: o Proper positioning of face masks covering the nose and mouth o Proper donning/doffing of PPE upon entering and exiting isolation rooms o Proper hand hygiene is performed prior to exiting resident rooms or having resident contact o Residents who are positive COVID-19 or suspect to be positive have face masks on if they are outside of their room, proper signage indicating isolation on their doorway and the door closed o Sufficient PPE is available in designated locations B. The Director of Nursing/Designee will review all Nursing Progress Notes for three (3) months to ensure any new onset of COVID-19 symptoms have been promptly to the physician, the resident placed on Contact/Droplet Precautions and relocated to the designated area for suspect COVID-19 cases in the facility. C. The Director of Nursing/Designee will review all Agency Orientation Records weekly for three (3) months to ensure a review of the Infection Prevention & Control program and the training program for this directed plan of correction has been complete for all new agency staff when reporting for their first shift. D. The consultant will participate in QA&A Committee Meetings for three (3) months. E. Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will	

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F 880	Continued From page 11 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 (organizer) 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 diagnosis of COVID-19). CNA #1 stated she	F 880	be determined by the Committee based on audit results. Responsibility: Director of Nursing	

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F 880	Continued From page 12 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	F 880		

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F 880	Continued From page 13 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 which included dementia, unspecified cerebrovascular disease, history of malignant neoplasm. 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	F 880		

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F 880	Continued From page 14 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 COVID -19 and hand hygiene completed prior to entering a non COVID-19 room. There is a "risk of transmission if this does not happen." The facility does practice extended	F 880		

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F 880	Continued From page 15 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 COVID -19 and preform hand hygiene prior to entering a non COVID-19 room. 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 with COVID-19 and has been working with the facility. He expected the facility staff	F 880		

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F 880	Continued From page 16 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)	F 880		

EXHIBIT 33

STATE OF NEW YORK : DEPARTMENT OF HEALTH

IN THE MATTER

OF

HOWARD A. ZUCKER, M.D., J.D., as Commissioner of Health of the State of New York, to determine the action to be taken with respect to:

COMPREHENSIVE AT ORLEANS, LLC

Respondent,

as operator of

THE VILLAGES OF ORLEANS HEALTH AND REHABILITATION CENTER
14012 ROUTE 31
ALBION, NY 14411

arising out of alleged violations of Article 28 of the Public Health Law of the State of New York, Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, and Governor's Executive Order 202.11

STIPULATION

AND

ORDER

NH-20-018

WHEREAS, the New York State Department of Health ("the Department") has made findings based upon an inspection of The Villages of Orleans Health and Rehabilitation Center, ("the Facility"); and

WHEREAS, the Department completed its survey of the Facility on May 9, 2020; and

WHEREAS, the Department's survey findings included an alleged violation of Article 28 of the Public Health Law (PHL) and Part 415 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR Part 415) and Governor's Executive Order 202.11, and

WHEREAS, prior to commencement of administrative enforcement action based upon the alleged violation by service of a Notice of Hearing and Statement of Charges, the Department and the Respondent engaged in settlement discussions; and

WHEREAS, the parties wish to resolve this matter by means of a settlement instead of an adversarial administrative hearing

NOW, THEREFORE, IT IS STIPULATED AND AGREED AS FOLLOWS:

1. This matter is settled and discontinued with prejudice. The Department shall not pursue administrative enforcement action against the Respondent pursuant to PHL Article 28, 10 NYCRR Part 415, and Governor's Executive Order 202.11 in connection with the findings set forth in the Statement of Deficiencies dated May 9, 2020, and the Addendum to this Stipulation and Order.

2. The Respondent admits, to resolve this administrative matter, to the existence of substantial evidence of violations of Public Health Law Section 2803(4), 10 NYCRR §§ 415.3(f)(2)(ii)(b) and 415.3(f)(2)(ii)(c), 415.19(a)(1), 415.19(a)(2), 415.19(b)(1) and Governor's Executive Order 202.11, based upon the findings set forth in the Statement of Deficiencies dated May 9, 2020, and the Addendum to this Stipulation and Order. The foregoing admission is without prejudice to the Respondent's rights, defenses, and claims in any other matter, proceeding, action, hearing, or litigation not involving the Department or any of its boards or councils authorized by the Public Health Law, including but not limited to those involving medical malpractice, personal injury, and/or negligence that may be made in a civil action for monetary damages.

3. Pursuant to PHL §§ 12(1)(a) and 206, the Respondent shall pay a civil penalty of Twenty Thousand ($20,000) within thirty (30) days of the effective date of this Stipulation and Order. Payment of this civil penalty shall be sent by certified mail and shall be made payable to the New York State Department of Health and forwarded to the New York State Department of Health, Bureau of Accounts Management, Room 2748, Corning Tower, Empire State Plaza, Albany, New York 12237-0016. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes, but is not limited to, the imposition of interest, late payment charges and collection fees, referral

to the New York State Department of Taxation and Finance for collection, and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

4. Nothing herein contained shall be construed to preclude the Department from pursuing any and all sanctions or remedies authorized by the Public Health Law against any individual employed by or practicing in association with the Facility for any violations based upon the findings set forth in the Statement of Deficiencies dated May 9, 2020. Such sanctions and remedies may include, but are not limited to, administrative proceedings brought pursuant to PHL § 2803-d (relating to patient abuse, mistreatment, or neglect), PHL § 230 (relating to professional medical conduct), and PHL Article 28-D (relating to the practice of nursing home administration). A copy of this Stipulation and Order shall be sent to the Bureau of Nursing Home Administrator Licensure for whatever action, if any, it may deem appropriate. Nor shall this Stipulation and Order be construed to preclude the Department, the Public Health and Health Planning Council, or any other boards or councils authorized by the Public Health Law from considering the Department's findings referenced herein in any matter before it.

5. It is further stipulated and agreed by the Respondent and the Department that there exist valid and sufficient grounds, as a matter of fact and law, for the issuance of this Stipulation and Order under the Public Health Law and the Respondent consents to its issuance, accepts its terms and conditions and waives any right to challenge this Stipulation and Order in a proceeding pursuant to Article 78 of the Civil Practice Law and Rules or in any other action or proceeding.

6. This Stipulation and Order shall be effective upon service on the Respondent or the Respondent's attorney or representative of a fully executed copy by personal service or by certified or registered mail.

DATED: Albany, New York
June 18, 2020

Comprehensive at Orleans, LLC.

BY: _____

Print Name: Steve Hefler

AGREED AND SO ORDERED:

DATED: Albany, New York
June 29, 2020

NEW YORK STATE DEPARTMENT OF HEALTH

_____

HOWARD A. ZUCKER, M.D., J.D.
Commissioner of Health

Inquiries to: Alvaro A. J. Salinero
Bureau of Administrative Hearings
Phone: (518) 473-1705
Email: alvaro.salinero@health.ny.gov

Mail Stipulation and Order to:

Alvaro A. J. Salinero, Esq.
New York State Department of Health
Corning Tower Building, Room 2495
Empire State Plaza
Albany, New York 12237-0029

Mail Payment to:

New York State Department of Health
Bureau of Accounts Management
Corning Tower, Room 2748
Empire State Plaza
Albany, New York 12237-0016

EXHIBIT 34

Accepted 9/7/20 CB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS On 8/11/20 and 8/12/20 Focused Infection Control COVID-19 survey and CHRC (Criminal History Record Check) review (NY00261898) was completed at The Villages of Orleans to determine if this facility was in compliance with state and Federal requirements related to proper infection prevention and control practices to prevent the development and transmission of COVID-19 and CHRC requirements. The facility was not in substantial compliance with participation requirements. Deficiencies were cited. Part 402 - Criminal History Record Check	F 000		

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

Electronically Signed | 09/08/2020

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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R 000	Initial Comments On 8/11/20 and 8/12/20 Focused Infection Control COVID-19 survey and CHRC (Criminal History Record Check) review (NY00261898) was completed at The Villages of Orleans to determine if this facility was in compliance with state and Federal requirements related to proper infection prevention and control practices to prevent the development and transmission of COVID-19 and CHRC requirements. The facility was not in substantial compliance with participation requirements. Deficiencies were cited.	R 000		
R 504 SS=E	Part 402 - Criminal History Record Check 402.4(a)(1) General Requirements Section 402.4 General Requirements. (a) (1) Each provider shall assure that criminal history information is requested, received, reviewed, and acted upon in a timely manner. Each provider shall designate one authorized person or, when necessary, to assure compliance with this Part more authorized persons, and shall submit the name, position, and contact information for each authorized person to the Department in the form and format required by the Department. This LICENSURE is not met as evidenced by: Based on interview and record review during the COVID-19 Infection Control Focus Survey (Complaint #NY00261898) completed on 8/12/20, the facility did not ensure that criminal history information was requested, received,	R 504	1. Employee 1 completed mandatory finger printing and will have supervisor sign-off sheets completed until the governing authority confirms employee 1's ability to work. Employee 2 completed finger printing and was approved to work by the governing authority to work. Employee 3 was removed from the employee roster/schedule and terminated from the CHRC system. 2. An initial audit was completed by the the human resources director and reviewed by the NHA to confirm new hires, for the period of 30 days prior to the correct action date of this survey, are in compliance with the facility Policy and procedure for criminal history background checks. An audit shall be completed once a week by the the the human resources director and reviewed NHA for 4 weeks to confirm new hires are in compliance with the facility policy and procedure for criminal history background checks. 3. The Director of Human Resources	09/07/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/06/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	08/12/2020

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

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R 504	Continued From page 1 reviewed, and acted upon in a timely manner. The facility did not initiate the CHRC process in a timely manner for one (Employee #1) of six new/prospective employees reviewed for compliance with the New York State (NYS) Department of Health (DOH) Criminal History Record Check (CHRC) process. The facility did not submit fingerprints in a timely manner for two (Employees #2 and 3) of six new/prospective employees reviewed for compliance with the New York State (NYS) Department of Health (DOH) Criminal History Record Check (CHRC) process. The findings are: Review of an undated facility policy and procedure (P&P) titled "Criminal Background Check" revealed the following: - Procedure: All those members looking to gain employment with the facility must first give permission to undergo a background check in accordance with New York State law. - Personnel: Application for employment: applicant submits to Human Resources department. - Authorization for search and exchange of information notice regarding criminal history record check. Human Resources department has applicant complete authorization form (NYSDOH 102 form) and complete acknowledgement on notice, Human Resources retains this document and placed in separate identified binder. - Proof of submission (NYSDOH 103 form) maintained in separate identified binder. - Approved applications: (NYSDOH determination letter) copies of approved application are placed in separate identified binder.	R 504	shall be re in-serviced by the administrator on the facility policy and procedure for completing checks and submissions to the governing authority for criminal history background checks. 4. Audits shall be reviewed at monthly QA to confirm and ensure compliance. The NHA will be responsible for the implementation and evaluation of this corrective action.	

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R 504	Continued From page 2 - Fingerprinting: The applicant shall be fingerprinted, at an official fingerprinting site and return official documents from the site to the Human Resources department. - This occurs if the NYSDOH CHRC system returns to the facility a notification requiring the employee to be fingerprinted. -Between the times fingerprinting is scheduled and an approved application is returned the applicant will be supervised at all times and a supervisor form will be completed for each shift worked and filed separately in a secured identified binder. Review of the personnel file for Employee #1 (agency Certified Nursing Assistant) revealed the employee was hired on 7/28/20, a consent for CHRC (DOH CHRC form 102) was obtained on 8/03/20 and the request for CHRC (DOH CHRC 103) was submitted electronically on 8/3/20 and the facility received a CHRC Non-Ident determination letter for the employee dated 8/6/20. Review of the facility and agency client schedule revealed Employee #1 worked at the facility on 7/28/20, 7/29/20, 7/30/20 and 8/3/20. During an interview on 8/12/20 at 10:23 AM the Human Resources Scheduling Director stated, the employee started working at the facility as an agency Certified Nursing Assistant on 7/28/20. The Human Resources Scheduling Director stated, she had made a mistake and missed the employee's first few days of employment (7/28/20, 7/29/20, 7/30/20 and 8/3/20) at the facility. On 8/3/20 she had the employee fill out the CHRC102 consent form and sent the employee's request for a criminal history check to CHRC. The Human Resources Scheduling Director stated, Employee #1 was an	R 504		

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R 504	Continued From page 3 agency Certified Nursing Assistant and usually worked on the Canal View unit. The facility had five resident units, but only three units had been consistently occupied by residents. Review of the personnel file for Employee #2 (Housekeeper) revealed the employee was hired on 6/18/20, a consent for CHRC (DOH CHRC form 102) was obtained on 6/18/20 and the request for CHRC (DOH CHRC 103) was submitted electronically on 8/11/20. The file contained no fingerprint documentation for the employee. Review of supervisor logs revealed the employee worked at the facility for 32 days between 6/18/20 and 8/7/20 and the section of the logs labeled CHRC fingerprint results received on: was blank. No date for the CHRC results was written on the log. During an interview on 8/11/20 at 10:32 AM the Human Resources Scheduling Director stated, the employee started working at the facility as a Housekeeper on 6/18/20. The facility had hired a lot of employees in June of 2020 and she had made a mistake and overlooked this employee. The Human Resources Scheduling Director was not aware the employee's information had not been submitted to CHRC until the surveyor had requested CHRC information for the employee. The facility had no fingerprint documentation for the employee. The Human Resources was a Housekeeper, she was not aware of any specific unit the employee was assigned to and housekeepers usually worked throughout the building. The facility had five resident units, but only three units had been consistently occupied by reScheduling Director stated, Employee #2 sidents. Review of the personnel file for Employee #3 (Certified Nursing Assistant) revealed the	R 504		

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R 504	Continued From page 4 employee was hired on 5/2/20, a consent for CHRC (DOH CHRC form 102) was obtained on 5/1/20, the request for CHRC (DOH CHRC 103) was submitted electronically on 5/4/20 and the termination from CHRC (DOH CHRC 105) was submitted/ received on 6/26/20. The file contained no fingerprint documentation for the employee. Review of supervisor sign off sheet revealed the employee worked at the facility for 33 days between 5/1/20 and 6/12/20. During an interview on 8/11/20 at 10:35 AM the Human Resources Scheduling Director stated, the employee started working at the facility as a Certified Nursing Assistant on 5/1/20. Employee #3 missed their first fingerprint appointment and the Human Resources Scheduling Director was not able to schedule another fingerprint appointment for the employee before the employee stopped working at the facility. The facility had no fingerprint documentation for the employee. The Human Resources Scheduling Director stated, Employee #3 was a Certified Nursing Assistant and the employee usually worked on the Autumn View North and the Canal View Units. The facility had five resident units, but only three units had been consistently occupied by residents.	R 504		
R 514 SS=B	402.4(a)(1)(2) 402.4(b)(2)(i) General Requirements Section 402.4 General Requirements. ..... (b) Each provider shall develop and implement written policies and procedures related to conducting criminal history record checks. Such policies and procedures shall include criteria for: ..... (2) protecting the safety of persons	R 514	1. Employee 1 completed mandatory finger printing and will have supervisor sign-off sheets completed for days/shifts worked, until the governing authority confirms employee 1's ability to work. 2. An initial audit was completed by the the human resources director and reviewed by the NHA to confirm new hires, for the period of 30 days prior to the corrective action date of this survey, are in compliance with the facility Policy and	09/07/2020

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R 514	Continued From page 5 receiving services from temporary employees as follows: (i) Residential Health Care Facilities shall ensure that temporary employees do not have unsupervised physical contact with patients, by utilizing a person employed by the provider on the same nursing unit as the temporary employee, but such person employed by the provider need not be employed in the same department as the temporary employee. Such person must know the identity and assignment of each temporary employee so supervised in the residential health care facility at all times. Supervision must be documented in writing on a weekly basis and maintained in the temporary employee's personnel folder. This LICENSURE is not met as evidenced by: Based on interview and record review during the COVID-19 Infection Control Focus Survey (Complaint #NY00261898) completed on 8/12/20, the facility did not ensure that temporary employees do not have unsupervised physical contact with residents, by utilizing a person employed by the provider on the same nursing unit as the temporary employee but such person employed by the provider need not be employed in the same department as the temporary employee. Such person must know the identity and assignment of each temporary employee so supervised in the residential health care facility at all times. Supervision must be documented in writing on a weekly basis and maintained in the temporary employee's personnel folder. One (Employee #1) of six prospective employees reviewed for supervision pending the results of criminal history record checks (CHRC) did not have evidence of weekly supervision as required.	R 514	procedure for criminal history background checks. An audit shall be completed once a week for 4 weeks, by the the the human resources director and reviewed by the NHA to confirm new hires are in compliance with the facility policy and procedure for criminal history background checks, in the event they require supervisor sign off sheets for days/shifts they will be included on the audit. 3. The Director of Human Resources shall be re in-serviced on the facility policy by the administrator and procedure for completing checks and submissions to the governing authority for criminal history background checks. 4. Audits shall be reviewed at monthly QA to confirm and ensure compliance. The NHA will be responsible for the implementation and evaluation of this corrective action.	

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R 514	Continued From page 8 The finding is: Review of an undated facility policy and procedure titled "Criminal Background Check" revealed the following: - Procedure: All those members looking to gain employment with the facility must first give permission to undergo a background check in accordance with New York State law. - Personnel: Application for employment: applicant submits to Human Resources department. - Authorization for search and exchange of information notice regarding criminal history record check. Human Resources department has applicant complete authorization form (NYSDOH 102 form) and complete acknowledgement on notice. Human Resources retains this document and placed in separate identified binder. - Proof of submission (NYSDOH 103 form) maintained in separate identified binder. - Approved applications: (NYSDOH determination letter) copies of approved application are placed in separate identified binder. - Fingerprinting: The applicant shall be fingerprinted, at an official fingerprinting site and return official documents from the site to the Human Resources department. - This occurs if the NYSDOH CHRC system returns to the facility a notification requiring the employee to be fingerprinted. - Between the times fingerprinting is scheduled and an approved application is returned the applicant will be supervised at all times and a supervisor form will be completed for each shift worked and filed separately in a secured identified binder.	R 514		

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R 514	Continued From page 7 Review of the personnel file for Employee #1 (agency Certified Nursing Assistant) revealed the employee was hired on 7/28/20, a consent for CHRC (DOH CHRC form 102) was obtained on 8/03/20 and the request for CHRC (DOH CHRC 103) was submitted electronically on 8/3/20 and the facility received a CHRC Non-Ident determination letter for the employee dated 8/6/20. The employee's file contained no supervision documentation for the employee. Review of the facility and agency client schedule revealed Employee #1 worked at the facility on 7/28/20, 7/29/20, 7/30/20 and 8/3/20. During an interview on 8/12/20 at 10:23 AM the Human Resources Scheduling Director stated, the employee started working at the facility as an agency Certified Nursing Assistant on 7/28/20. The Human Resources Scheduling Director stated, she had made a mistake and missed the employee's first few days of employment (7/28/20, 7/29/20, 7/30/20 and 8/3/20) at the facility. On 8/3/20 she had the employee fill out the CHRC102 consent form and sent the employee's request for a criminal history check to CHRC. The facility had no supervision documentation for the employee. The Human Resources Scheduling Director stated, Employee #1 was an agency Certified Nursing Assistant and usually worked on the Canal View unit. The facility had five resident units, but only three units had been consistently occupied by residents. 402.4(b)(2)(i)	R 514		

EXHIBIT 35

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F 000	INITIAL COMMENTS On 12/17/20 at The Villages of Orleans Health and Rehab Center a Focused Infection Control COVID-19 survey was completed to determine if this facility was in compliance with state and Federal requirements related to proper infection prevention and control practices to prevent the development and transmission of COVID-19. The facility was not in substantial compliance with participation requirements and deficiencies were cited.	F 000		
F 880 SS=E	42 CFR Part 483.80 Infection Control 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	F 0880 Infection Prevention & Control I. The following actions were accomplished for the residents identified in the sample: - The following facility staff members were educated on Center for Disease Control (CDC) and NY State Department of Health (DOH) guidelines regarding the awareness and prevention of the spread of COVID-19, specifically, that all staff must be screened - checked for COVID-19 symptoms (e.g., fever, cough, difficulty breathing, or other respiratory symptoms), including temperature checks every 12 hours while on duty. o Licensed Practical Nurse (LPN) #2 o CNA #1 o CNA #2 o Door Screener #1 o Door Screener #2 o ADON o Administrator o DON –(no longer employed) II. The following corrective actions will be	01/22/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Electronically Signed | 01/13/2021

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F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880	implemented to identify other resident who may be affected by the same practice: All residents have the potential to be affected by this practice. • All residents, not currently diagnosed with COVID-19, will be assessed for exposure to COVID-19, specifically, temperature, pulse oximetry, and respiratory assessment. III. The following system changes will be implemented to assure continuing compliance with regulations: • Preventing the spread of COVID-19 Infection Control policy has been reviewed and revised to include re-screening of employees every 12 hours while on duty. • Employee Log Pandemic Surveillance sheet was reviewed and updated to include re-screening for staff working greater than 12 hours. • All staff will be educated on the revised policy, specifically: • All staff to be checked for COVID-19 symptoms (e.g., fever, cough, difficulty breathing, or other respiratory symptoms), including temperature checks upon the start of each shift and every 12 hours while on duty. • Door Screener and Nursing supervisors/designees will be educated to ensure that COVID screening has been completed and documented on the Employee Log Pandemic Surveillance sheet for all employees that are working greater than 12 consecutive hours. IV.The facility's compliance will be	

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F 880	Continued From page 2 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during the COVID-19 Infection Control Focus Survey completed on 12/17/20, 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, the facility did not ensure staff were screened for COVID-19 symptoms (e.g., fever, cough, difficulty breathing, or other respiratory symptoms), including temperature checks every 12 hours while on duty. The finding is: Executive Order 202.11, dated March 27, 2020, documented the following, "Any guidance issued by the New York State Department of Health related to prevention and infection control of COVID-19 shall be effective immediately and shall supersede any prior conflicting guidance issued by the New York State Department of Health (NYSDOH) and any guidance issued by any local board of health, any local department of health, or any other political subdivision of the State related to the same subject." Review of a NYS DOH DAL (Dear Administrator Letter) NH-20-07, dated 5/11/20, documented "This Directive supplements . . . the DAL sent on April 29, 2020." The DAL further documented "With respect to COVID-19, state and federal rules and regulations require that NHs adhere to appropriate safety measures including, but not limited to. . . . Requiring all staff to be checked for COVID-19 symptoms (e.g., fever, cough,	F 880	monitored utilizing the following quality assurance system: As per the Directed Plan of Correction, a QA&A Committee meeting was held on January 7, 2021 to examine this deficiency. The Administrator/designee will conduct ten (10) random audits weekly for four (4) weeks and then monthly for two (2) months to ensure that all staff working greater than 12 consecutive hours have received COVID re-screening and this has been documented on the Employee Log Pandemic Surveillance sheet. Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results. The consultant will participate in QA&A Committee Meetings for three (3) months. Completion Date: 1/22/21 Responsibility: Administrator	

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F 880	Continued From page 3 difficulty breathing, or other respiratory symptoms), including temperature checks upon the start of each shift and every 12 hours while on duty." Review of an undated facility document titled "Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)" documented the facility will actively verify absence of fever and respiratory symptoms when employees report to work at the beginning of their shift and will document temperature, absence of shortness of breath, new or change in cough and sore throat and other criteria as identified by State guidance. The policy did not include screening staff every 12 hours while on duty. During an interview on 12/15/20 at 9:05 AM, the Director of Nursing (DON), in the presence of the facility Administrator, stated they received two positive staff results on 12/14/20 and the most recent resident COVID-19 positive result was received on 11/29/20. Review of "Orleans/ Timecards/ TC Nursing" (employee timesheets) dated 11/9/20 through 12/15/20 revealed: - Licensed Practical Nurse (LPN) #2 worked 16 hours shifts on 11/9/20, 11/10/20, 11/14/20, 11/17/20 through 11/19/20, 11/23/20 through 11/25/20, 11/27/20, 11/28/20, 12/1/20 through 12/3/20, 12/7/20 through 12/9/20, and 12/12/20 - Certified Nursing Assistant (CNA) #1 worked 16 hours shifts on 11/23/20, 11/24/20, 11/26/20 through 11/28/20, 12/2/20 through 12/5/20, 12/6/20, 12/11/20 and 12/12/20. - CNA #2 worked 16 hours shifts on 12/9/20,	F 880		

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	336212	A. BUILDING _____ B. WING _____	12/17/2020

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THE VILLAGES OF ORLEANS HEALTH AND REHAB CENTER	14012 ROUTE 31 ALBION, NY 14411

(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) COMPLETE DATE
F 880	Continued From page 4 12/10/20, 12/11/20, and 12/14/20. Review of "Employee Log Pandemic Surveillance" sheets dated 11/17/20 through 11/28/20 revealed LPN #2 and CNA #1 were not screened every 12 hours while on duty on the respective dates they worked a 16-hour shift. Review of "Employee Log Pandemic Surveillance" sheets dated 12/7/20 through 12/14/20 revealed LPN #2, CNA #1 and CNA #2 were not screened every 12 hours while on duty on the respective dates they worked a 16-hour shift. The screening tool revealed no instructions that employees are to be re-screened every 12 hours while on duty. During an interview on 12/15/20 at 9:35 AM, CNA #1 stated she gets screened for COVID-19 signs/symptoms and gets her temperature taken when she first enters the facility at the start of her shifts. She stated if you go out of the building for lunch or leave for whatever reason you have to be re-screened when you enter, but if you do not leave the building you do not have to be re-screened. During an interview on 12/15/20 at 2:17 PM, CNA #2 stated she was working a 16 hour shift today and she often works double shifts (16 hours) from 2:00 PM to 6:00 AM the following morning. She stated she is screened upon entry to the facility and does not need to be re-screened a second time unless she is leaving the building and coming back. During an interview on 12/15/20 at 2:25 PM, LPN #2 stated that she works 16 hour shifts three times per week and was scheduled today 6:00 AM to 10:00 PM. She stated she is screened at the beginning of her shift and does	F 880		

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F 880	Continued From page 5 not need to be re-screened at any point throughout her 16 hours. During an interview on 12/15/20 at 10:38 AM, Door Screener #1 stated if staff go out for food and come back into the facility they get screened again, if staff just go outside, they don't get re-screened. Door Screener #1 stated she only works 8-hour shifts and was not sure if staff needed to be screened every 12 hours. During an interview on 12/15/20 at 2:20 PM, Door Screener #2 stated she is assigned to the door for screening of staff and/or visitors on Tuesdays, Wednesdays and Thursdays from 2:00 PM to 8:00 PM. She stated staff are screened in the morning or when they first come in for their scheduled shift and staff are not re-screened if they are working a double shift. If staff do not go outside of the building for any reason, they do not get re-screened or have their temperature re-taken. During an interview on 12/15/20 at 2:46 PM, the Assistant Director of Nursing (ADON)/ Infection Preventionist (IP), in the presence of the DON, stated she was not familiar with the NYS DOH DAL regarding screening staff every 12 hours while on duty. She stated the expectation is for staff to get screened for symptoms of COVID-19 and have their temperature taken at the start of their shift and it is only done once per day. During an interview on 12/15/20 at 3:25 PM, the facility Administrator stated staff are expected to complete the screening questionnaire and have their temperature taken at the facility entrance when they enter the building at the start of their shift. If staff go out for lunch, then they get re-screened when they come back, but it is not documented anywhere. If they do not exit the	F 880		

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F 880	Continued From page 6 building, they do not get re-screened or have their temperature taken again. There is no documentation of re-screening of staff working over 12 hours. The Administrator stated they did not think staff had to be re-screened if they remained in the building when working over 12 hours. During a telephone interview on 12/17/20 at 1:30 PM, the Director of Nursing (DON) stated she was familiar with the guidance on screening staff every 12 hours while on duty. The DON stated she could not find any education provided to staff on the guidance from the NYS DOH (DAL) regarding screening and that it had not been implemented in the facility. 415.19(a)(1), 400.2	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or	F 886	F 0886 COVID-19 Testing - Residents & Staff I. The following actions were accomplished for the residents identified in the sample. • The following facility staff members were educated on Center for Disease Control (CDC) and NY State Department of Health (DOH) guidelines regarding the awareness and prevention of the spread of COVID-19, specifically conducting testing consistent with current standards of practice including the use of proper PPE (N-95 mask) during COVID -19 specimen collection. o LPN #1 o LPN #3 o ADON/IP o Administrator o DON –(no longer employed) • The following facility staff members were educated on Center for Disease Control (CDC) and NY State Department of Health	01/22/2021

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F 886	Continued From page 7 suspected exposure to COVID-19: (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county. (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or	F 886	(DOH) guidelines regarding the awareness and prevention of the spread of COVID-19, specifically regarding accurately tracking to ensure all staff are tested as per current state and federal guidelines. o ADCN/IP o HR Director o Administrator o HR Director o DON –(no longer employed) • Additionally the following staff members were tested for COVID o LPN #1 o LPN #3 o CNA #3 o Dietary #2 o Housekeeper #1 II. The following corrective actions will be implemented to identify other resident who may be affected by the same practice: All residents have the potential to be affected by this practice. • All residents, not currently diagnosed with COVID-19, will be assessed for exposure to COVID-19, specifically, temperature, pulse oximetry, and respiratory assessment • All staff conducting COVID-19 testing will be educated on wearing N-95 masks during specimen collection. • A review of staffing sheets for the most recent 1 week period prior to the implementation of these corrective actions was reviewed to ensure all staff received a COVID-19 test in the past seven days. III. The following system changes will be	

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F 886	Continued From page 8 processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during the COVID-19 Infection Control Focused Survey completed on 12/17/20 the facility did not ensure residents and facility staff, including individuals providing services under arrangement and volunteers, were tested and documented that testing was complete with the results of each test for COVID-19. Specifically, for three (Licensed Practical Nurse (LPN) #1, Certified Nurse Aide (CNA) #3 and Dietary #2) of three employees reviewed for COVID-19 testing, the facility had no documented evidence of weekly COVID-19 test results during a facility COVID-19 outbreak. In addition, the facility did not conduct testing and specimen collection in a manner that is consistent with current infection control practices as staff did not wear an N95 mask during COVID-19 specimen collection. The findings are: The Centers for Medicare & Medicaid Services (CMS) QSO-20-38-NH dated 8/26/20, "Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID19 Focused Survey Tool," documented: the facility is required to obtain documentation that the required testing was completed during the timeframe that corresponds to the facility's testing frequency. In addition, the guidance documented: "During specimen collection, facilities must maintain proper infection control	F 886	implemented to assure continuing compliance with regulations: • Preventing the spread of COVID-19 Infection Control policy has been reviewed and revised to include wearing of N-95 masks during COVID-19 specimen collection. All licensed staff performing specimen collection have been educated. • New Tracking process and audit form was implemented to track COVID-19 testing more accurately. Administrator, ADON and HR Director have been educated on the new tracking process. IV.The facility's compliance will be monitored utilizing the following quality assurance system: As per the Directed Plan of Correction, a QA&A Committee meeting was held on January 7, 2021 to examine this deficiency. The Administrator/designee will conduct weekly audits for four (4) weeks and then monthly for two (2) months to ensure that all staff working have been tested within the past week for COVID-19 as per most recent guidance. The Administrator/designee will conduct twice weekly visual audit to ensure staff conducting COVID-19 specimen collection are wearing N-95 masks. Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results	

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F 886	Continued From page 9 and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens." The CMS guidance further documented: "For outbreak testing, all staff and residents should be tested, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result." Per the CMS guidance, an outbreak is defined as a new COVID-19 infection in any staff or resident. New York State Executive Order (EO) 202.30 (dated May 10, 2020), as modified by EO 202.40 (dated June 9, 2020), provides: "the operator and administrator of all nursing homes and all adult care facilities, which are located in regions that have reached Phase Two of reopening, must test or make arrangements for the testing of all personnel, including all employees, contract staff, medical staff, operators and administrators, for COVID-19, once per week." 1. During an interview on 12/15/20 at 9:05 AM, the Director of Nursing (DON), in the presence of the facility Administrator, stated they received two positive staff results on 12/14/20 and the most recent resident COVID-19 positive result was received on 11/29/20. The DON stated staff testing is completed weekly on Tuesdays and Thursdays. Review of an untitled resident line list provided by the facility for COVID-19 positive residents revealed one resident had tested positive for COVID-19 on 11/25/20.	F 886	The consultant will participate in QA&A Committee Meetings for three (3) months. Completion Date: 1/22/21 Responsibility: Administrator	

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F 886	Continued From page 10 Review of an untitled employee line list provided by the facility for COVID-19 positive employees revealed six staff members tested positive for COVID-19 between 10/16/20 and 12/15/20. Review of "Orleans/Time-Cards/TC Nursing" dated 10/11/20 through 12/12/20 revealed: -Licensed Practical Nurse (LPN) #1 worked in the facility on 10/11/20, 10/12/20, 10/15/20, 10/16/20, 10/19/20, 10/20/20, 10/23/20, 10/24/20, 10/25/20, 10/26/20, 10/27/20, 10/29/20, 10/30/20, 11/2/20, 11/3/20, 11/4/20, 11/6/20 11/7/20, 119/20, and 11/11/20 -Certified Nurse Aide (CNA) # 3 worked in the facility on 10/11/20, 10/13/20, 10/15/20, 10/27/20, 10/29/20, 11/1/20, 11/3/20, 11/5/20 11/8/20, 11/10/20, 11/12/20, 11/15/20, 11/17,20, 11/19/20, 11/22/20, 11/24/20, 11/26/20, 11/29/20, 12/1/20, 12/2/20, 12/3/20, 12/5/20, 12/8/20, 12/9/20, and 12/10/20. -Dietary #2 worked in the facility on 11/6/20, 11/7/20, and 11/8/20. Review of an undated untitled employee line list, that the DON and Assistant Director of Nursing (ADON) Infection Preventionist (ADCN/IP) identified as used to track facility staff weekly COVID-19 test results for October, November and December 2020, revealed there was no documented evidence that LPN #1 had COVID-19 tests completed 10/11/20 through 11/11/20, no documented evidence CNA #3 had COVID-19 tests completed 10/11/20 through 10/15/20 or 10/25/20 through 12/12/20, and no documented evidence Dietary #2 had tests completed 11/1/20 through 11/9/20. During an interview on 12/15/20 at 1:57 PM, the	F 886		

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F 886	Continued From page 11 DON stated the Director of Human Resources (HR) tracks all staff to ensure they are in compliance with weekly testing. The DON stated that she and the ADON review the results, but HR tracks the staff to make sure all staff that are scheduled to work are tested. During an interview on 12/15/20 at 2:00 PM, the Assistant Director of Nursing (ADON) Infection Preventionist (IP) stated it is the expectation that all staff that work in the facility get a COVID-19 swab test weekly unless they are on vacation. In that case, they get tested as soon as possible so they can return to work. She stated staff are taught that in orientation. During an interview on 12/15/20 at 2:45 PM the ADON/IP reviewed the dates of missing COVID-19 test results for LPN #1, CNA #3 and Dietary #2. The ADON stated she could not explain why LPN #1, CNA #3 and Dietary #2 were missing so many weekly tests and added "that doesn't look good." During an interview on 12/15/20 at 3:00 PM, the HR Director stated that, under the direction of the prior DON, she had previously done the tracking to ensure all staff that worked in the facility were in compliance with getting their weekly COVID-19 test. She stated the ADON had been tracking staff results for the past month or two. The HR Director stated, if staff test results get put into her mailbox, she puts them in the ADON's mailbox because she took over the responsibility of tracking staff results. Additionally, she stated if staff are not tested they cannot work until they get tested. During an interview on 12/15/20 at 3:25 PM, the Administrator stated it is the expectation of staff that they receive COVID-19 testing weekly. The	F 886		

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F 886	Continued From page 12 ADON is responsible for monitoring that staff are tested and keeps a spreadsheet. If staff are out of compliance with weekly COVID-19 testing they are not eligible to work until tested. During a telephone interview on 12/17/20 at 11:43 AM, the DON stated there was no additional documentation of COVID-19 test results for LPN #1, CNA #3 or Dietary #2. The DON stated there was a break in the facility tracking system to ensure all staff had a weekly COVID-19 testing completed. She stated the facility followed guidelines in the testing QSO from CMS and guidelines provided by New York State Department of Health (NYSDOH). 2. During an observation on 12/15/20 at 1:30 PM, LPN #1 completed a nares (nasal) swab for COVID-19 testing on an employee (Dietary #1) while wearing a gown, goggles, gloves and a cloth face mask. During an interview on 12/15/20 at 1:33 PM, LPN #1 stated he was trained on COVID-19 specimen collection by the ADON/IP. He stated, "the required PPE to be worn during specimen collection is a gown, gloves, goggles and a mask, but an N95 would probably be better, right?" LPN #1 stated N95 respirator masks are in stock and available for staff use within the facility. During an interview on 12/15/20 at 1:35 PM, LPN #3 was in the room waiting for a COVID-19 swab test and stated she had also been trained on specimen collection. LPN #3 stated she has completed COVID-19 swab testing on residents and that she wears a cloth mask during resident specimen collection, not an N95 mask. During an observation on 12/15/20 at 1:40 PM,	F 886		

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F 886	Continued From page 13 LPN #1 completed a nares swab for COVID-19 testing on LPN #3 wearing a gown, gloves, goggles and a cloth mask. During continued observation on 12/15/20 at 1:43 PM, LPN #1 completed a nares swab for COVID-19 on Housekeeper #1 wearing a gown, gloves, goggles and a cloth mask. During an interview on 12/15/20 at 9:05 AM, the Administrator stated they have ample supply of gowns, gloves, eye protection, surgical and N95 respirator masks. During an interview on 12/15/20 at 1:53 PM, the DON stated N95 masks are available in the facility and should be worn during COVID-19 specimen collection for infection control purposes. The DON stated she uses education materials provided by the laboratory and NYS DOH guidelines for COVID-19 specimen collection that included wearing an N95. During an interview on 12/15/20 at 1:57 PM, the ADON/IP stated the expectation of staff is to wear full PPE which includes gown, gloves, face shield or goggles and an N95 during specimen collection. LPN #1 should have been wearing an N95 to be protected from potential exposure. During a telephone interview on 12/17/20 at 11:43 AM, the DON stated there wasn't a facility specific policy and procedure on staff/resident testing or COVID-19 specimen collection, but the facility followed guidelines in the testing QSO from CMS and guidelines provided by New York State Department of Health (NYSDOH). 415.19(a)(1); 400.2	F 886		

EXHIBIT 36

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

February 3, 2021

The Villages of Orleans Health
and Rehabilitation Center
14012 Route 31
Albion, New York 14411

Re: Enforcement Action
Survey Date: 8/11/20, 2/26/20, 9/24/19
Repeat Citations

Dear Mr. Flugel:

You are hereby notified that on the above-referenced date, The Villages of Orleans Health and Rehabilitation Center was found to be in violation of the New York State Medical Facilities Code.

Pursuant to Section 12 of the Public Health Law, the facility is liable for civil penalties for violations of Article 28 of the Public Health Law and the New York State Medical Facilities Code. The violations for which a penalty is being sought fall under:

415.4(b)(1)(i)-Abuse Verbal, sexual, physical, and Mental, Corporal Punishment, and Involuntary Seclusion

In addition, a Notice of Violations poster is being forwarded to you and must be posted in a prominent location within the facility so that residents, their families and friends, staff, visitors, volunteers, and other interested parties may be informed of violations for which the Department of Health has initiated an enforcement referral. Upon request from these individuals, you must make available for review any statements of deficiencies or other materials furnished to you by the Department in connection with this notice. The Notice of Violations poster must remain prominently posted in the facility until the enforcement action is completed, (i.e. a Stipulation and Order is signed or an Order after hearing has been issued). Failure to follow this requirement constitutes a violation of 10 NYCRR, Part 413 related to the Consumer Information System.

Until this matter is resolved, the Department cannot make an affirmative statement as to the residential health care facility operator's character and competence as required by Section 2801-1(3) of the Public Health Law or current substantial compliance with all applicable codes, rules and regulations as required by Section 2802(3)(e) of the Public Health Law, as such pertains to any Certificate of Need application filed by the residential health care facility.

In the event that you wish to settle this matter without the necessity of a hearing, you may contact Mr. Mark Fleischer of the Department's Division of Legal Affairs at (518) 473-1707. A formal Notice of Hearing/Statement of Charges will be served, and a hearing will be scheduled if you do not contact Mr. Fleischer within 15 days of the date of this letter.

If you have any questions regarding programmatic issues, you may contact Anie Cyriac at anie.cyriac@health.ny.gov.

Sincerely,

Sheila McGarvey, Director
Division of Nursing Homes & ICF/IID Surveillance
Center for Health Care Provider Services and Oversight

Enclosure

cc: Mr. Mark Fleischer, Bureau of Administrative Hearings
Ms. Claudette Royal, Office of the Aging
Mr. Ross Zastrow, Regional Manager, Buffalo Regional Office
Mr. Bernard Fuchs, Owner/Operator

EXHIBIT 37

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THE VILLAGES OF ORLEANS HEALTH AND REHAB CENTER	14012 ROUTE 31 ALBION, NY 14411

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F 609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00244727) completed on 9/24/19, the facility did not ensure that all alleged violations involving abuse are reported immediately but not later than 2-hours after the allegation is made if	F 609	The following corrective action has been implemented for the deficiency cited: 1. The facility policy & procedure titled "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property" has been updated to include bold print that is easily noted for the abuse reporting requirements. A copy has been provided for all staff in the facility to read and acknowledge. 2. The Administrator and Director of Nursing have re-educated themselves on the abuse reporting requirements and F tags 602-610. 3. The Assistant Director of Nursing (ADON) has been educated on the abuse reporting criteria , and that she must report immediately to Administrator or Director of Nursing any suspicion of abuse, neglect, mistreatment or misappropriation of resident property. ADON has been supplied with printed F tags 602-610 to read and be knowledgeable of. She is aware DON is on call 24/7 and she must call, not text, with any questions/concerns she may have. 4.All staff will be in-serviced annually on abuse reporting requirements. The Administrator will report on staff participation percentages annually at QA. The Administrator and Director of Nursing are responsible for implementation of this plan of correction.	10/25/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/04/2019

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	09/24/2019

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

(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) COMPLETE DATE
F 609	Continued From page 1 the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for two (Residents #1, 2) of four residents reviewed for abuse. Specifically, the facility did not report within the 2-hour time frame to the New York State Department of Health (NYS DOH) an incident of alleged sexual abuse of a female resident (Resident #1) perpetrated by a male resident (Resident #2) that occurred on 9/8/19 at 9:30 AM. The facility reported the incident on 9/9/19 at 3:21 PM. The findings are: Review of a facility policy and procedure titled "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property" dated revised 8/17 revealed in response to allegations of abuse, neglect, exploitation or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2-hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities. The facility should not complete a full investigation before reporting it to the NYS DOH. In order to gather the best evidence relevant to the allegation, it is necessary that the NYS DOH be told there is "reasonable cause" to believe abuse has occurred. Therefore, timing	F 609		

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	335212	A. BUILDING _____ B. WING _____	09/24/2019

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F 609	Continued From page 2 is important and there should be no delay. 1. Resident #1, a 69-year old female, was admitted to the facility on 12/4/08 with diagnoses including Traumatic Brain Injury (TBI), depression and right hemiparesis (weakness on one side of body). The Minimum Data Set (MDS- a resident assessment tool) dated 8/16/19 documented the resident had moderate cognitive impairment, had impairment of both upper and lower extremities on one side, required extensive assist for activities of daily living (ADL'S) and is not ambulatory. She had a history of being hypersexual in the past with inappropriate behaviors. 2. Resident #2, a 69-year old male, was admitted to the facility on 2/19/19 with diagnoses including COPD (chronic obstructive pulmonary disease), schizoaffective disorder and diabetes mellitus. The MDS dated 8/30/19 documented the resident had moderate cognitive impairment, required one person assist with most ADL'S and ambulated with a walker. He had a history of inappropriate comments and behaviors towards women. Review of a facility investigation dated 9/11/19 documented that on 9/8/19, Resident #2 was found in Resident #1's room standing at the side of the bed with his pants down around his ankles. The witnessing Certified Nursing Aide (CNA) was unable to see exactly what happened. Resident #1 stated, I was bad girl" and referred to Resident #2 as her boyfriend. Resident #2 denied everything stating he had no idea about the incident. The residents were separated, and a Velcro stop sign was attached to Resident #1's door. She was later transferred to the locked dementia unit. Resident #2 was put on continuous 1:1 with a staff member.	F 609		

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	335212	A. BUILDING _____ B. WING _____	09/24/2019

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F 609	Continued From page 3 Review of the NYS DOH Automated Complaint Tracking System Complaint/ Incident Investigation Report revealed; Date/Time of occurrence: 9/8/19 at 9:30 AM Resident #2 entered Resident #1's room and dropped his pants to his ankles, stood at side of Resident #1's bed where she was lying. The CNA saw this and entered the room and told Resident #2 to leave. The CNA made sure Resident #1 was alright and contacted the supervisor. Submitted by facility: 9/9/19 at 03:21:06 PM. During an interview on 9/24/19 at 2:00 PM, the Administrator stated he was not aware of the 2-hour reporting requirement if the events that cause the allegation involve abuse. During an interview on 9/24/19 at 2:05 PM, the Director of Nursing stated she was not aware of the 2-hour reporting requirement if the events that cause the allegation involve abuse. 415.4(b)(4)	F 609		

EXHIBIT 38

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING _____ B. WING _____	02/26/2020

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

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F 000	INITIAL COMMENTS An Abbreviated Survey ACTS reference #NY00252666 was conducted on 2/24/20 through 2/26/20 at The Villages of Orleans Health and Rehabilitation Center to determine compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The following deficiencies were cited as a result of this survey: 42 CFR 483.10 Resident rights 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation	F 000		
F 563 SS=F	483.10(f)(4)(ii)-(v) Right to Receive/Deny Visitors §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when	F 563	1. Resident rights, including the residents right to see and refuse guests at their choosing, were reviewed with resident 1 - care plan updated. 2. All residents were interviewed to identify their respective preference for visitation and care plans updated. policies are reviewed on a rotating basis during resident council to ensure residents are aware of their rights. 3. The interdisciplinary care team - including the activities director was re-inserviced on resident rights. Residents rights were reviewed with the interdisciplinary care team. Director of Social Services and Social Service assistant shall be re-in-serviced by the Administrator on the importance of ensure residents rights are met. New admissions shall have their resident's rights reviewed with them on their admission. 4.An audit was completed to ensure Residents Right to see and refuse guests at times of their choosing was reviewed with all in house residents. An audit shall	07/08/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 563	Continued From page 1 such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00252666) completed on 2/26/20, the facility did not ensure that the resident has a right to receive visitors of his or her choosing at the time of his or her choosing subject to the resident's right to deny visitation when applicable, and the facility must have written policies and procedures regarding the visitation rights of residents. One (Resident #1) of three residents reviewed had issues. Specifically, Resident #1 requested that a frequent visitor in the facility did not return to visit him/her after an alleged incident was reported. The visitor had access to the facility and the resident's room for at least 24 hours after the request was made. In addition, the facility did not have policies and procedures in place regarding visitation rights of residents. The finding is: 1. Resident #1 had diagnoses including diabetes mellitus (DM). The Minimum Data Set (MDS - a resident assessment tool) dated 2/18/20 documented the resident was cognitively intact. Review of a Social Work Progress Note dated 2/17/20 at 1:44 PM documented Social Worker (SW) #1 met with Resident #1 per the resident's request. Resident #1 informed SW #1 they were feeling uncomfortable with the behavior of someone who was seen as a "friend and nothing	F 563	occur on all new admissions for two weeks to ensure new admissions have received and have had their rights reviewed on admission including visitor preference. 5. The facility shall review audits at the monthly QA. The administrator shall be responsible for the implementation and evaluation for this corrective action.	

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F 563	Continued From page 2 more". This visitor had befriended the resident and was frequently at the nursing home visiting many other residents. Resident #1 reported this person was displaying unwanted behavior that had escalated and was becoming more forceful and aggressive. Resident #1 stated the incidents were causing the resident to be up all night contemplating on what to do about it. Resident #1 completed a written statement that was signed by the resident and Social Worker #1. Social Worker #1 provided this to the Administrator. Review of a Social Work Progress Note written by the Director of Social Work dated 2/18/20 at 12:14 PM documented she met with Resident #1 to follow-up from the complaint that was made the day prior about a visitor. The Director of SW completed a Brief Interview for Mental Status (BIMS) and a Mini-Mental Evaluation showing resident was cognitively intact. Resident #1 stated that several incidents were not reported immediately as the visitor had befriended the resident. The visitor was asked to stop several times, but the behavior escalated. Resident #1 agreed to speak with law enforcement and asked that the visitor not allowed to enter the room anymore. Review of a verbal statement from Resident #1 written by SW #1 dated 2/17/20 documented for the past month the visitor had been inappropriate and making the resident feel uncomfortable. Resident #1 thought it would stop but the visitor was becoming more forceful with escalating behaviors. Resident #1 reported the incident to the night nurse because they "just wish and want" the visitor to stop. During a telephone interview on 2/25/20 at 1:46 PM, the overnight (2/16/20 to 2/17/20) Licensed	F 563		

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F 563	Continued From page 3 Practical Nurse (LPN #8) revealed Resident #1 told her about the visitor at approximately midnight on 2/17/20. Resident #1 expressed concern about the visitor's behavior and the fact that it was escalating. LPN #8 wrote a note on the 24-hour nursing report for the Social Worker to see Resident #1. LPN #8 was not sure if the visitor was a friend to Resident #1 and did not think to report it. During an interview on 2/25/20 at 9:40 AM, a Housekeeper/Union President stated she started receiving complaints from the staff regarding the visitor named in the alleged incident. The visitor was becoming hostile and belligerent to staff and was seen in the facility after regular hours. The Administrator had been informed and spoke with the visitor, but the behavior continued. Statements were obtained from staff and given to the Administrator regarding the escalating behavior. The visitor was known to have the code to the doors for entrance to the facility after hours. A request had been made by staff for the code to be changed but it had not been done so far. During an interview on 2/24/20 at 10:10 AM, Social Worker #1 stated she was asked to see Resident #1 at morning report on 2/17/20. The Social Worker was told by Resident #1 that the visitor was making them uncomfortable and was becoming more forceful with unwanted behaviors. Resident #1 reported this had been going on for approximately a month. Social Worker #1 reported the incident to the Administrator. During an interview on 2/24/20 at 10:20 AM, the Director of Social Work stated she read Resident #1's statement on 2/18/20 and discussed the incident with the Administrator.	F 563		

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F 563	Continued From page 4 The Director of Social Worker went to interview Resident #1. The visitor was observed walking towards Resident #1's room as the director was walking out. The Director of Social Worker asked staff to stay with the visitor while she went to get the Administrator. The Administrator asked the visitor to leave the building. During an interview on 2/24/20 at 2:00 PM, the Administrator stated he went to see Resident #1 on 2/17/20 after he was made aware of the allegations. On 2/18/20 he was told the visitor was in the building. He told the visitor there was a complaint from a resident about him and not to return to the facility until the investigation was completed. Signs were posted throughout the facility with the visitor's picture stating the visitor was not allowed in the building and to call the police if the visitor was seen in the building. The visitor has been coming to the facility for many years and does a lot for the residents. There is no receptionist at any door of the facility. The doors automatically unlock at 8:00 AM and lock at 8:00 PM. There is a code for staff to enter the building before 8:00 AM and after 8:00 PM. He had changed the code to the building, but the old code was still working. Additionally, he stated there were no policies and procedures regarding visitation or for door code use. There were no lists available of visitors who have the code to get in because visitors should call the unit if the door was locked in order to come into the facility. During an interview on 2/25/20 at 2:15 PM, Resident #1 stated the visitor came into their room on 2/17/20, did not stay long and did not touch Resident #1. During a telephone interview on 2/25/20 at 4:30 PM, the visitor stated he had the code to the	F 563		

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F 563	Continued From page 5 building, if it had not changed but that he had not been back to try. 415.3(e)(2)(iv)(d)	F 563		
F 609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint	F 609	1. The Administrator of record at the time of the event, was terminated from employment. Resident 1 had their care plan reviewed and updated. The identified individual was banned from the property with a notice presented by the local police and notice was presented to employees posted at employee time clocks, to immediately call the police if the individual was identified. 2. Security codes will be updated at entrances. Video cameras were reviewed. policy and procedure for reviewing and updating security codes was reviewed and confirmed by the QA committee. 3. All employees will be re-inserviced on abuse and abuse reporting guidelines by the RN educator with a post test to monitor understanding and will occur annually as part of regulatory required annual education. Nursing Supervisors, director of nursing and administrator were in-serviced by the RN educator on facility P/P and state reporting guidelines. 4. An initial audit was completed to ensure there were no other allegations of abuse outstanding. an audit shall occur monthly to confirm there are no outstanding allegations of abuse. An audit shall be conducted by the administrator or designee once per day for 1 week and once per week for 4 weeks to ensure the security codes are active. The administrator shall keep and maintain a separate computer	07/08/2020

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F 609	Continued From page 6 #NY00252666) completed on 2/26/20, the facility did not ensure that all alleged violations involving abuse were reported immediately but no later than 2-hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the Administrator of the facility and to other officials (including to the State Survey Agency.) One (Resident #1) of three residents reviewed for abuse and neglect had issues. Specifically, a Licensed Practical Nurse (LPN #8) did not report a resident's allegation of sexual abuse to the nursing supervisor on the night she was informed. In addition, the Administrator did not report the allegation to the New York State (NYS) Department of Health (DOH) or law enforcement agency until the day after he was informed of the allegation. The allegation of sexual abuse was not reported to the State Agency within two hours as required. The finding is: Review of a facility policy and procedure (P&P) titled "Abuse, Neglect, Mistreatment and Misappropriation of Property" dated 10/19 revealed the facility prohibits any abuse of residents. The facility requires all employees who have reasonable cause to believe that any situation of Resident abuse, neglect or mistreatment has occurred to immediately notify his/ her supervisor. All staff should know that despite facility policies and procedures that may require reporting internally, they must be sure the New York State Department of Health (NYS DOH) is notified. All employees, residents and visitors shall have access to reporting forms and "hotline" number for reporting acts of abuse, neglect or mistreatment. Additionally, posters and brochures containing necessary information to make a report will be made available to	F 609	screen specific to video surveillance in the administrators office to monitor facility security. 5. The QA committee shall review audits at the monthly QA meeting to ensure continued compliance Nursing Supervisors, director of nursing and administrator were in-serviced by the RN educator on facility P/P and state reporting guidelines.The administrator shall be responsible for the implementation and evaluation for this corrective action.	

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THE VILLAGES OF ORLEANS HEALTH AND REHAB CENTER	14012 ROUTE 31 ALBION, NY 14411

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F 609	Continued From page 7 residents, visitors and employees. The facility has established a mechanism which informs the reporter in writing whether a report was actually made to the NYS DOH, so they can be confident the appropriate corrective action will be applied. If this protocol is followed by the individual, the Administrator or Director of Nursing (DON) to whom the report was given fails to forward a "reportable event" to the NYS DOH, the Administrator or DON will be held accountable for not reporting and/or not having an effective reporting policy. The section titled "When to report" documented "In response to allegations of abuse, neglect, exploitation or mistreatment", the facility must: - Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24-hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and other officials including the State Survey agency in accordance with State law through established procedures. - The facility should not complete a full investigation before reporting to the NYS DOH. In order to gather the best evidence relevant to the allegation, it is necessary that the NYS DOH be told there is "reasonable cause" to believe that abuse occurred therefore timing is important and there should be no delay. 1. Resident #1 has diagnoses including diabetes mellitus. Review of the Minimum Data Set (MDS - a resident assessment tool) dated 2/18/20	F 609		

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	335212	A. BUILDING _____ B. WING _____	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 8 revealed the resident was cognitively intact. Review of a Social Work Progress Note dated 2/17/20 at 1:44 PM revealed the Social Worker (SW #1) met with Resident #1 per the resident's request. The resident informed the Social Worker of feeling uncomfortable with someone who visits the facility and was seen as a "friend and nothing more". This person befriended the resident and was frequently at the nursing home visiting many other residents. Over the past month this person started holding the resident's hand and rubbing (his/her) arm, but this weekend it involved more, becoming more forceful and aggressive. Resident #1 stated the incident caused the resident to be up all night contemplating what to do about it. Resident #1 provided a statement, that was signed by the resident and provided to the Administrator by SW #1. The statement from the resident dated 2/17/20, written by SW #1, documented that for the past month the visitor was inappropriate and made the resident feel uncomfortable. The resident documented the visitor was becoming more forceful and behaviors were escalating despite being asked to stop. Resident #1 reported the incident to the night nurse on 2/17/ because the resident "just wished and wanted" the visitor to stop. A handwritten statement, signed by the Administrator, dated 2/17/20, documented that the Administrator attempted to speak with Resident #1 on 2/17/20 at approximately 1:00 PM and 5:05 PM, but the resident was sleeping. At 5:15 PM, the Administrator spoke to the resident who stated that the visitor recently held his/her hand and pressed it up against his private parts and kissed him/her on the mouth	F 609		

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F 609	Continued From page 9 and ear. The resident repeatedly asked the visitor to stop; he was good for a while and went back to doing these things. The Administrator told the resident that he could limit the visitor's visitation rights such as no visits in rooms or supervised visits in common areas only. The resident stated the intention to speak with the visitor one more time and ask him to cease his actions or take it to a higher authority to deal with it. The Administrator stated he would follow-up with the resident after he/she spoke to the visitor, to discuss next steps. A Social Work Progress Note dated 2/18/20 at 12:14 PM documented that the Director of Social Work met with the resident to follow-up the resident's complaint about the visitor yesterday. The Director of Social Work completed a Brief Interview for Mental Status (BIMS) and a Mini-Mental Evaluation (assessments used to determine a resident's cognition) showing the resident was cognitively intact. Resident #1 stated that several incidents were not reported immediately to staff because the visitor had befriended the resident. The visitor was asked "to stop" several times, but the behaviors escalated. Resident #1 agreed to speak with law enforcement and asked that the visitor not be allowed to enter the (resident's) room anymore. Interview with the Social Worker (SW #1) on 2/24/20 at 10:10 AM revealed she was informed during morning report on Monday 2/17/20 that the resident wanted to speak with her. Resident #1 told an overnight nurse (LPN #8) about an incident that happened on 2/16/20 and the resident requested to see the Social Worker. After the Social Worker spoke with the resident, she reported the information to the Administrator. The Administrator told her to do the investigation and he would see the resident	F 609		

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F 609	Continued From page 10 later. Interview with the Director of Social Work on 2/24/20 at 10:20 AM revealed she read the resident's statement and asked the Administrator what was being done about the incident. The Administrator told her he was looking into it. He was not sure if the information was accurate because the resident might have a urinary tract infection and was receiving antibiotics. The Social Worker told the Administrator that the incident needed to be reported to the NYS DOH and law enforcement and that the visitor should not be allowed in the facility. The Social Worker stated she notified local law enforcement of the incident. Interview with the Administrator on 2/24/20 at 12:00 PM revealed he was aware of the two-hour reporting rule but had no comment as to why he did not report the incident timely. He stated he told the visitor on 2/18/20 that there was a complaint from a resident about him and not to return to the facility until the investigation was complete. Interview with the resident on 2/25/20 at 1:30 PM revealed he/she reported the incident to the overnight LPN #8 around midnight on 2/17/20. Telephone interview with the overnight (2/16/20 to 2/17/20) LPN #8 on 2/25/20 at 1:46 PM revealed the resident told her about the visitor at approximately midnight on 2/17/20. The resident expressed concern about the visitor's behavior and the fact that it was escalating. The LPN stated she wrote a note on the 24-Hour Nursing Unit Report for the Social Worker to see the resident. She was not sure if the visitor was a friend to the resident and did not think to report it to the night shift Nursing Supervisor. The LPN	F 609		

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F 609	Continued From page 11 stated she was not aware of the two-hour regulation for reporting alleged abuse. Review of the NYS DOH Automated Complaint Tracking System (ACTS) Complaint/ Incident Investigation Report revealed the date/time of occurrence was 2/17/20 at 1:00 PM and the incident was submitted by the facility to the NYS complaint intake unit on 2/18/20 at 12:34 PM. 415.4(b)(4)	F 609		
F 610 SS=D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00252666) completed on 2/26/20, the facility did not have evidence that all alleged	F 610	1. The Administrator of record at the time of the event was terminated, a review of the investigation was completed by the new Administrator and Director of Nurses. The residents care plan was reviewed and updated. The identified individual was banned from the property with a notice presented by the local police and notice was presented to employees posted at employee time clocks, to immediately call the police if the individual was identified 2. Security codes will be updated at entrances. Video camera system was reviewed by the Administrator. Policy and procedure for reviewing and updating security codes was reviewed and confirmed by the QA committee. 3. Nursing Supervisors, director of nursing and administrator were in-serviced by the RN educator on facility P/P on completing investigations to the fullest extent practicable. 4. An initial audit was completed to ensure any allegations of abuse were submitted timely, including investigations and witness statements. An audit shall occur monthly to	07/08/2020

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F 610	Continued From page 12 violations were thoroughly investigated for one (Resident #1) of three residents reviewed for abuse and neglect. Specifically, there was a lack of a timely investigation into the resident's allegations of sexual abuse and the lack of a thorough investigation into the allegation to include statements from potential witnesses. The finding is: A facility policy and procedure (P&P) titled "Abuse, Neglect, Mistreatment and Misappropriation of Property" dated 10/19 revealed documentation is required with respect to accidents and incidents that must be recorded pursuant to 10 NYCRR 415.30 (i). With respect to allegations of abuse, mistreatment and neglect, facilities must document that the allegations are thoroughly investigated pursuant to NYCRR 315.4 (b)(3), including any incident that is not consistent with routine operation of the facility or routine care of the resident. The supervisor who has been informed of the allegation is to complete the initial investigation report and forward a copy to the Administrator. This notification is in addition to immediate notification to the Director of Nursing (DON). 1. Resident #1 had diagnoses including diabetes mellitus (DM). The Minimum Data Set (MDS - a resident assessment tool) dated 2/18/20 documented the resident was cognitively intact. A 24-Hour Nursing Unit Report dated 2/16/20 for the night shift revealed documentation that Resident #1 "would like to speak to Social Work". Review of a Social Work Progress Note dated 2/17/20 at 1:44 PM revealed Social Worker #1 met with Resident #1 per the resident's request.	F 610	confirm allegations of abuse were reported timely. An audit shall be conducted by the administrator or designee once per day for 1 week and once per week for 4 weeks to ensure the security codes are active. The Administrator shall keep and maintain a separate computer screen specific to video surveillance in the Administrators office to monitor facility security. 5. The QA committee shall review audits at the monthly QA meeting to ensure continued compliance Nursing Supervisors, director of nursing and administrator were in-serviced by the RN educator on facility P/P and state reporting guidelines.The Administrator shall be responsible for the implementation and evaluation for this corrective action.	

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F 610	Continued From page 13 The resident informed the Social Worker of feeling uncomfortable with someone who visits the facility and was seen as a friend and nothing more. This person comes into the nursing home a lot to visit many other residents. Over the past month this person started holding hands and rubbing the resident's arm, but this past weekend it involved more. The resident complained of being up most of Sunday night after the incident happened and was contemplating what to do. The resident completed a written and signed report. The Social Worker provided this to the Administrator for follow up. Review of a verbal statement from Resident #1 written by Social Worker #1 dated 2/17/20 documented for the past month the visitor was inappropriate and made the resident feel uncomfortable. The statement documented the visitor was becoming more forceful and behaviors were escalating in spite of being asked to stop. The incident was reported to the night nurse because the resident "just wish and want the visitor to stop". Review of a written statement from the Administrator documented that he spoke with the resident on 2/17/20 at 5:15 PM the resident stated the visitor was recently holding his/her hand and pressing it up against his private parts and kissed him/her on the mouth and ear. The resident repeatedly asked him to stop; he was good for a while and went back to doing these things. The Administrator told the resident that he could limit the visitor's visitation rights such as no visits in rooms or supervised visits in common areas only. The resident stated the intention was to speak with the visitor one more time and ask him to cease his actions or take it to a higher authority to deal with it. The	F 610		

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F 610	Continued From page 14 Administrator stated he would follow-up with the resident after he/she spoke to the visitor, to discuss next steps. Review of a Social Work Progress Note written by the Director of Social Work dated 2/18/20 at 12:14 PM documented she met with Resident #1 to follow-up from the complaint that was made the day prior about a visitor. The Director of SW completed a Brief Interview for Mental Status (BIMS) and a Mini-Mental Evaluation showing resident was cognitively intact. Resident #1 stated that several incidents were not reported immediately as the visitor had befriended the resident. The visitor was asked to stop several times, but the behavior escalated. Resident #1 agreed to speak with law enforcement and asked that the visitor not allowed to enter the room anymore. There were no additional statements from potential witnesses to review. Review of Progress Notes for Resident #1 dated 2/17/20 to 2/18/20 revealed there was no documented evidence that a physical assessment of the resident was completed after the incident was reported on 2/17/20. During an interview on 2/24/20 at 12:00 PM, the Administrator stated the paperwork available for review was the resident's statement, the Social Worker's statement and his statement. During an interview on 2/24/20 at 2:00 PM, the Administrator stated he went to see the resident on 2/17/20 after he was made aware of the allegations. On 2/18/20, he told the visitor there was a complaint from a resident about him and not to return to the facility until the investigation was completed.	F 610		

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F 610	Continued From page 15 During a telephone interview on 2/25/20 at 1:46 PM, the overnight (2/16/20 to 2/17/20) Licensed Practical Nurse (LPN #8) revealed Resident #1 told her about the visitor at approximately midnight on 2/17/20. Resident #1 expressed concern about the visitor's behavior and the fact that it was escalating. LPN #8 wrote a note on the 24-hour nursing report for the Social Worker to see Resident #1. LPN #8 did not think to report it. 415.4(b)(3)	F 610		

EXHIBIT 39

Accepted KL 9/21/20

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/21/2020
FORM APPROVED
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS An Abbreviated Survey Complaint ACTS reference # (NY00260552) was conducted for The Villages of Orleans on 8/3/20, 8/4/20, 8/6/20, 8/7/20, and 8/11/20 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation	F 000		
F 600 SS=D	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #NY00260552) 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	F 600	1. Resident 1 was moved to a different unit within the facility and their Care Plan reviewed and updated to reflect resident's preference and shall be in high visible location per resident 1's preference. Accommodations were made for resident 2 to transfer to a facility closer to resident 2's family, family was in agreement. Resident 2 was discharged safely from the facility. Both Resident 1 and 2 were evaluated for capacity. 2. An initial audit was completed for in-hourse residents by the DON or or ADON to confirm no outstanding or open cases of presumed abuse, mistreatment or neglect have been displayed by residents. An audit shall occur weekly, beginning upon confirmation of POC, by the DON or ADON for 4 weeks and monthly for 2 months to confirm no outstanding or open cases of presumed abuse mistreatment or neglect. An audit shall be completed by the DON and MD, for current residents, to confirm all residents capacity's are reviewed and updated if applicable. Capacity shall be reviewed on admission and at quarterly care plan meetings. 3. The Administrator re-inserviced	09/21/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/2020

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F 600	Continued From page 1 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 residents. Abuse shall mean inappropriate physical contact with a resident, which harms or is likely to cause harm to the resident. 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 which include dementia, diabetes mellitus (DM), and depression. 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	F 600	the IDT team including the newly appointed DON on abuse reporting guidelines. All staff shall be re-inserviced on identifying possible abuse mistreatment or neglect and facility P/P and immediate interventions upon identification of possible abuse mistreatment or neglect. The NHA and DON reviewed and revised the policy and procedure for determining capacity and the IDT team was re-inserviced on the facility's P/P for determining capacity. 4. Audits shall be reviewed at monthly QA to confirm and ensure compliance. The NHA will be responsible for the implementation and evaluation of this corrective action.	

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F 600	Continued From page 2 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 which include dementia, depression, and anxiety. The MDS dated 7/16/2020 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	F 600		

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F 600	Continued From page 3 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 diagnosis of dementia. LPN #1 stated both residents had a diagnosis of dementia and asked them if they both consented to the sexual activity. 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.	F 600		

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	335212	A. BUILDING _____ B. WING _____	08/11/2020

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F 600	Continued From page 4 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 600		
F 609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609	1. Resident 1 was moved to a different unit within the facility and their Care Plan reviewed and updated to reflect resident's preference and shall be in high visible	09/21/2020

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F 609	Continued From page 5 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00260552) 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	F 609	location per resident 1's preference. Accommodations were made for resident 2 to transfer to a facility closer to resident 2's family, family was in agreement. Resident 2 was discharged safely from the facility. 2. An initial audit was completed for in-hourse residents by the DON or or ADON to confirm no outstanding or open cases of presumed abuse, mistreatment or neglect have been displayed by residents. An audit shall occur weekly, beginning upon confirmation of POC, by the DON or ADON for 4 weeks and monthly for 2 months to confirm no outstanding or open cases of presumed abuse mistreatment or neglect and in the event cases are identified, are confirmed as reported timely. 3. The Administrator re-inserviced the IDT team including the newly appointed DON on abuse reporting guidelines and P/P - upon review, no update to abuse reporting P/P was needed as the policy matched the current regulation guidelines. All staff shall be re-inserviced on identifying possible abuse mistreatment or neglect and facility P/P and immediate interventions upon identification of possible abuse mistreatment or neglect. The NHA and DON reviewed and revised the policy and procedure for determining capacity. The policy for reporting abuse 4. Audits shall be reviewed at monthly QA to confirm and ensure compliance - potential reportable were submitted timely. The NHA will be responsible for the implementation and evaluation of this corrective action.	

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F 609	Continued From page 6 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. Resident #1 had diagnoses which include dementia, diabetes mellitus (DM) The Minimum Data Set (MDS - a resident assessment tool) dated 7/17/20 documented Resident #1 had moderate cognitive impairments, usually understands and was usually understood. The MDS documented, physical behavioral symptoms directed toward others (e.g., hitting,	F 609		

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F 609	Continued From page 7 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 which include dementia, depression, and anxiety. The MDS dated 7/16/20 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	F 609		

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F 609	Continued From page 8 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)	F 609		

EXHIBIT 40

Accepted on 5/24/21 by CB (not printed)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS A Recertification and Complaint Investigation Survey, ACTS reference # (NY00261044, NY00252205, NY00244872, NY 00272930) was conducted at Villages of Orleans Health and Rehabilitation Center from 4/19/21 through 4/23/21 and 4/26/21 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey. 42 CFR Part 483.12 Freedom from Abuse, Neglect and Exploitation 42 CFR Part 483.21 Comprehensive Resident Centered Care Plan 42 CFR Part 483.25 Quality of care 42 CFR Part 483.70 Administration	F 000		
F 609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609	I. The following corrective actions were accomplished for the residents found to have been affected by the deficient practice: • Resident # 247 was assessed, an investigation determined there was no evidence of abuse, mistreatment, or neglect and a report was entered into the Health Commerce System on 4/23/21 II. All residents have the potential to be affected by the deficient practice. • The following corrective actions will be taken: Administrator and Director of Nursing have reviewed the past 30 days of Accident and Incident Reports, specifically to ensure all incidents of abuse, specifically, injury of unknown origin have been identified and reported to the NYSDOH. Staff Development has provided education to the Administrator, Director of	06/24/2021

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

Electronically Signed | 05/21/2021

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 609	Continued From page 1 §483 12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during the Standard survey completed on 4/26/21, the facility did not ensure that all alleged violations including abuse, neglect, exploitation or mistreatment including injuries of unknown source, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the Administrator of the facility and other officials (including to the State Survey Agency and the Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one (Resident #247) of six residents reviewed. Specifically, Resident #247 sustained a fracture of unknown origin that was not reported to the New York State Department of Health (NYS DOH) as required within the two-hour time frame. The finding is: Review of a facility policy and procedure (P&P) titled "Abuse, Neglect, Mistreatment and Misappropriation of Property" dated 10/19 documented all staff should know that despite facility P&P that may require reporting internally,	F 609	Nursing, Assistant Director of Nursing, all nursing supervisors (day/evening and night), and unit managers on the New York State Department of Health Incident Reporting requirements specifically: o Ensure that all alleged incidents involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator or director of nursing. o The administrator or director of nursing are responsible 24 hrs/day-7 days/week to report alleged incidents alleged incidents involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property to the NYSDOH within 2 hours of identification of the incident. III. In an effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • Abuse policy has been reviewed with no changes indicated. • Staff Development has provided education to the Director of Nursing, Assistant Director of Nursing, Nursing Supervisors on all shifts and Unit Managers on the abuse reporting policy with emphasis on understanding what constitutes abuse specifically related to injuries of unknown origin and requirements for timely reporting to the Health Commerce System. IV. The facility compliance will be monitored utilizing the following quality assurance system: • An accident and incident audit	

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F 609	Continued From page 2 they must be sure the NYS DOH is notified. The section titled, "When to report" documented "In response to allegations of abuse, neglect, exploitation or mistreatment", the facility must: - Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24-hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and other officials including the State Survey agency in accordance with State law through established procedures. 1. Resident #247 was admitted to the facility with diagnoses including dementia, anxiety, and repeated falls. Review of the Minimum Data Set (MDS- a resident assessment tool) dated 4/15/21 documented the resident was usually understood, usually understands, and had severe cognitive impairment. The MDS further documented the resident required extensive assist of one person for all activities of daily living and was non-ambulatory. Review of the comprehensive Care Plan dated 4/15/21 documented the resident had a right foot fracture. Interventions included to follow physician's orders for weight bearing and to anticipate the resident's needs. Review of the facility "Investigation Summary" completed by the Director of Nursing (DON) dated 4/13/21, documented the DON was notified at 8:00 AM of blue bruising on Resident #247's right fourth toe including the top of the	F 609	tool will be developed that includes all elements of reporting requirements including the 2 hour notification to the NYSDOH. • All accident and incidents will be audited using an A/I reporting audit tool, daily by the Director of Nursing for three (3) months to ensure that all incidents of suspected or reported abuse, specifically injuries of unknown origin have been identified and reported to the NYSDOH within 2 hours. • Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results. Responsible Party: Director of Nursing	

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F 609	Continued From page 3 foot. An X-ray completed on 4/13/21 revealed a fracture of the fourth and fifth toes. The Investigation Summary further documented the cause of the fractures was unknown. The investigation was signed by the DON and the Administrator. The section "report to the New York State Department of Health" was checked "No". Review of the NYS DOH Automated Complaint Tracking System (ACTS) (software that logs and tracks nursing home complaints) from 4/13/21 through 4/22/21 revealed Resident #247's fracture of unknown origin was not reported. During an interview on 04/23/21 at 9:38 AM, the Occupational Therapy Assistant (OTA) stated she noted the bruise on the Resident #247's foot around breakfast time when she fixed the resident's sock and the resident had no complaints of pain. The OTA stated she reported the bruise to the nurse right away. During an interview on 04/23/21 at 9:48 AM, the Licensed Practical Nurse (LPN) #1 stated she was notified by a CNA that during morning care the resident's foot was bruised on the whole top of the foot. LPN #1 stated she reported it to the RN supervisor, who then called the MD. LPN #1 stated she was unsure how the injury occurred and would consider it an injury of unknown origin. During an interview on 04/23/21 at 1:02 PM, the DON stated she was responsible for completing the investigation of Resident #247's injury of unknown origin. The DON stated when the bruising to the resident's right foot was reported to her, she assessed the area, which looked blueish in color and she interviewed LPN #1. The DON stated she was unsure of the origin of	F 609		

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F 609	Continued From page 4 the injury and it should have been reported to NYSDOH within 24 hours. The DON stated she was unsure if the injury should have been reported within 2 hours or 24 hours, but she did not report it. During an interview on 04/23/21 at 2:14 PM, the Administrator stated he was familiar with the resident's right foot fracture and believed the injury of unknown origin was reported to NYS DOH by the DON, and it should have been be reported within 2 hours. 415 4(b)(4)	F 609		
F 610 SS=D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted	F 610	I. The following corrective actions were accomplished for the residents found to have been affected by the deficient practice: • Resident # 247 was assessed, and an investigation was completed for signs of abuse, mistreatment, or neglect. Specifically, all staff likely to have information over the previous 48 hours were interviewed and/or provided statements indicating that the resident's plan of care was followed. The investigation determined there was no evidence of abuse, mistreatment, or neglect. II. All residents have the potential to be affected by the deficient practice. • The Administrator, Director of Nursing have reviewed the past 30 days of Accident and Incident Reports, specifically to ensure all alleged incidents involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property abuse, have been identified, thoroughly investigated, including interview/witness statements from staff	06/24/2021

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F 610	Continued From page 5 during a Standard survey completed on 4/26/21, the facility did not ensure that all alleged violations of abuse and neglect were thoroughly investigated for one (Resident #247) of three residents reviewed. Specifically, there was a lack of employee interviews and employee statements to rule out abuse regarding an injury of unknown, fractures of the residents right foot fourth and fifth toes. The finding is: A facility policy and procedure (P&P) titled "Abuse, Neglect, Mistreatment and Misappropriation of Property" dated 10/19 documented accidents and incidents must be recorded. With respect to allegations of abuse, mistreatment and neglect, facilities must document that the allegations are thoroughly investigated. The P&P further documented the nursing supervisor /administrative staff will ensure resident and employee statements and any information requiring further investigation are completed, this may require obtaining statements from each direct care giver over the past 24 hours or more. Additional statements will be completed with other individuals who may have pertinent information regarding the incident and/or the cause of the incident. 1. Resident #247 was admitted to the facility with diagnoses including dementia, anxiety, and repeated falls. Review of the Minimum Data Set (MDS- a resident assessment tool) dated 4/15/21 documented the resident was usually understood, usually understands, and had severe cognitive impairment. The MDS further documented the resident required extensive assist of one person for all activities of daily living and was non-ambulatory.	F 610	likely to have information. III. In an effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • The accident/incident investigation policy has been reviewed with no changes. • Staff Development has provided education to the DON, ADON, Nursing Supervisors (day, night and evening) and Unit Managers on facility investigation policy and procedures specifically obtaining statements/interviews from all appropriate staff likely to have information regarding incident/accident. IV. The facility compliance will be monitored utilizing the following quality assurance system: • An accident and incident audit tool will be developed that includes all elements of reporting requirements including interview/witness statements from all staff likely to have information. • Accident and Incident reports will be audited daily by the Administrator/Designee using above audit tool for three (3) months to ensure that all injuries of unknown origin have been identified and thoroughly investigated, including obtaining statements and/or interviewing appropriate staff likely to have information. • Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results. Responsible Party: Director of Nursing	

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F 610	Continued From page 6 The comprehensive Care Plan dated 4/15/21 documented Resident #247 had a right foot fracture with interventions to follow physicians' orders for weight bearing and to anticipate needs. Review of the facility "Investigation Summary" completed by the Director of Nursing (DON) dated 4/13/21, documented the DON was notified at 8:00 AM of blue bruising on Resident #247's right fourth toe including the top of the foot. An X-ray completed on 4/13/21 revealed a fracture of the fourth and fifth toes. The Investigation Summary further documented the cause of the fractures was unknown. The investigation summary documented "employees interviewed" and documented the Occupational Therapy Assistant (OTA) was interviewed. There was no documented evidence a statement was obtained from the OTA and there were no additional employees interviewed or statements obtained. The physician's progress note dated 4/13/21 documented Resident #247 was seen for an acute visit and had some bruising to the right foot. There appeared to be some tenderness, staff indicated there was no known trauma, and the x-ray revealed fractures of the right fourth and fifth toes. During an interview on 4/23/21 at 9:38 AM, the OTA stated she noted the bruise on Resident #247's foot around breakfast time when fixing the residents sock and the resident had no complaints of pain. The OTA stated she reported the bruise to the nurse right away and was not asked to write a statement. During an interview on 4/23/21 at 9:48 AM, Licensed Practical Nurse (LPN) #1 was notified	F 610		

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F 610	Continued From page 7 by a certified nurses aide (CNA) that during morning care the resident's foot was bruised on the entire top of her foot. LPN #1 stated the bruising was reported to the RN (registered nurse) supervisor, who then called the MD. LPN #1 did not know how the injury occurred. LPN #1 stated she was not asked to write a statement. During an interview on 4/23/21 at 1:02 PM, the DON stated she was responsible for completing the investigation for Resident #247 injury of unknown orgin. The DON stated she interviewed the nurse on the day shift (LPN #1), and that she did not interview any other staff members or obtain written statements. The DON stated she was unsure of the origin of the injury. During an interview on 4/23/21 at 2:14 PM, the Administrator stated staff should have been interviewed and statements obtained.	F 610		
F 656 SS=D	415.4(b)(3) 483.21(b)(1) Develop/Implement Comprehensive Care Plan §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	F 656	I. The following corrective actions were accomplished for the residents found to have been affected by the deficient practice: • Resident #35 and #51: Comprehensive care plans were updated specific to resident's anticoagulant use • Resident #35 and #87: Comprehensive care plans were updated specific to resident's antipsychotic medications. II. All residents have the potential to be affected by the deficient practice. • All residents, currently receiving antipsychotic or anticoagulant medications, have had their care plans reviewed and updated, as necessary.	06/24/2021

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F 656	Continued From page 8 (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 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during a Standard survey completed on 4/26/21, the facility did not ensure that a person-centered comprehensive care plan was developed with measurable objectives and timeframes to meet a resident's medical and nursing needs for three (Resident #35, 51, and 87) of five residents reviewed. Specifically, there was no comprehensive care plan developed for use of anticoagulant (blood thinner) (#35, #51) and antipsychotic medications (#35, #87).	F 656	III. In an effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • Facility Care Plan policy was reviewed without changes • Staff Development has provided re-education to the Unit Managers, MDS coordinator, Director of Nursing, Assistant Director of Nursing and Social Worker on Care Plan policy. • Unit managers were educated that they are responsible for ensuring implementation of care plans for anticoagulation and antipsychotic medications IV. The facility compliance will be monitored utilizing the following quality assurance system: • An audit tool will be developed that includes timely implementation of care plans for anticoagulation and antipsychotic medications • Medication orders will be audited weekly using the above audit tool by the Director of Nursing for three (3) months to ensure that all residents receiving anticoagulant or antipsychotic medications have a comprehensive care plan in place addressing these medications. • Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results Responsible Party: Director of Nursing	

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F 656	Continued From page 9 The findings are: Review of an undated facility policy and procedure (P&P) titled "Comprehensive Care Plan, Person Centered" revealed the interdisciplinary team (IDT) are to implement a comprehensive, person centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The Care Plan (CP) should incorporate identified problem areas, risk factors, identified problems, and reflect treatment goals, timetables, and objectives in measurable outcomes. 1. Resident #51 had diagnoses including diabetes, depression, and atrial fibrillation (irregular often rapid heart rate that causes poor blood flow). Review of the Minimum Data Set (MDS - a resident assessment tool) dated 3/5/21 documented the resident had moderate cognitive impairment. The MDS documented the resident received antianxiety, antidepressant and anticoagulant. Review of the current physician orders, "Medication Review Report," signed by the physician on 4/4/21, documented the following physician's orders: -Eliquis (medication used to reduce the risk of strokes and blood clots) -Escitalopram (antidepressant medication) -Buspar (antianxiety medication) Review of the current comprehensive care plan (CCP) with a revision date of 3/18/21 documented a focus area of risk for falls related to depression, medications, pain, and poor safety awareness. There was no care plan	F 656		

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F 656	Continued From page 10 developed with measurable goals and interventions for depression, anxiety, or the use of psychotropic medications. Additionally, there was no care plan developed with measurable goals and interventions for the diagnosis of atrial fibrillation, the use of anticoagulant medication, or potential risks of increased bleeding. During an interview on 4/26/21 at 12:03 PM, Licensed Practical Nurse (LPN) Unit Manager (UM) #4 stated it was very important for psychotropic and blood thinning medication use to be documented on the CCP so that nurses and aides know to how to guide their care for safety, interventions, and side effects of medications. LPN UM #4 reviewed resident #51 CCP and stated she did not see "anything at all" regarding psychotropic medications or blood thinning medications and that should all be on the CCP. During an interview on 4/26/21 at 11:40 AM, the Director or Nursing (DON) stated nursing is responsible for CCP development and it starts at the time of admission with every diagnosis. If something changes with a resident, new medications or diagnosis, the expectation is to update the CCP. Residents should have all pertinent information on the CCP so that it can be used as a guide for care. If a resident has depression, anxiety or is taking a blood thinning medication there should be a care plan developed to address it with measurable goals and interventions. 2. Resident # 87 had diagnoses including convulsions (an episode of uncontrolled muscle spasms along with altered consciousness), cirrhosis (chronic disease of the liver), and encephalopathy (brain disease that alters brain function). The MDS dated 3/24/21 documented	F 656		

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F 656	Continued From page 11 the resident had severe cognitive impairment. The MDS documented the resident received antipsychotic medication and had a seizure disorder. Review of the current physician orders, "Medication Review Report," signed by the physician on 4/16/21, documented the following physician's orders: -Abilify (antipsychotic medication) -Keppra (anticonvulsant medication) -Topamax (antiepileptic drug used for various types of seizures) -Clobazam (medication used to treat seizures) -Ativan (used to treat seizures) -Vimpat (medication used to treat seizures) Review of Physician's Progress Note dated 4/20/21 documented the resident was sent out for evaluation of increasing belligerent behavior and agitation. The resident was sent to the emergency room, evaluated by a psychiatrist, and recommended a trial of Risperdal (antipsychotic medication). Review of the Medication Administration Record (MAR) dated 4/1/21 through 4/30/21 revealed and order for Risperdal 0.5mg (milligrams) by mouth two times per day with an order date of 4/20/21. Review of the current comprehensive care plan (CCP) with a revision date of 4/21/21 documented a focus area of potential behaviors related to chronic pain, dementia, depression, and encephalopathy with a plan to administer medications as ordered by the physician. There was no care plan developed for the use of psychotropic/antipsychotic medications and there was no care plan developed with	F 656		

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F 656	Continued From page 12 measurable goals and interventions for the diagnosis of seizures. During an interview on 4/26/21 at 10:34 AM, the Social Worker (SW) stated she was responsible for care plan (CP) development for antipsychotic/psychotropic medication use. She stated she was not aware that the resident's antipsychotic medications were not on the CP. As soon as medications are ordered they should be put on the CP. Nursing should have updated the CP for medications and behaviors. During an interview on 4/26/21 at 12:03 PM, LPN #4 UM stated if medication changes occurred, they get added to the CP as soon as the change occurs. The nurse rounding with the physician would be responsible for updating the CP if there are new orders. LPN #4 UM stated it was very important for antipsychotic usage and seizure disorder to be documented on the CP so that nurses and aides know to how to guide their care for safety, interventions, and side effects of an antipsychotic medication. LPN UM #4 reviewed Resident #87 CP and stated she did not see "anything at all" regarding seizures or antipsychotic medication use and that should all be on the CP. During an interview on 4/26/21 at 11:40 AM, the Director or Nursing (DON) stated if a resident has seizures it should be on the resident's care plan. 3 Resident #35 had diagnoses which include chronic respiratory failure, cerebral infarct (stroke), and anxiety disorder. Review of the MDS dated 3/30/21 documented the resident had moderately impaired cognition and used anticoagulant and antipsychotic medications.	F 656		

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F 656	Continued From page 13 Review of the Medication Review Report dated 2/18/21 revealed an order for Eliquis (anticoagulant blood thinning agent) 5 milligram (mg), 1 tab by mouth (po) two times a day related to atrial fibrillation (irregular often rapid heart rate that causes poor blood flow). Additionally, an order for Seroquel (antipsychotic - mood altering medication) 50 mg give 1 tab at bedtime for anxiety disorder. Review of Resident #35's current undated CCP revealed there was no care plan developed to address the use of blood thinning and antipsychotic medications including potential side effects. During an interview on 4/26/21 at 11:00 AM, the SW stated she would address an antipsychotic medication on the CCP, but she did not know about Resident 35's use of Seroquel. The SW stated nursing should also address anticoagulants and antipsychotics on the CCP. During an interview on 4/26/21 at 12:03 PM, LPN #4 UM stated it was very important for anticoagulation therapy and antipsychotic medication usage to be documented on the CCP, so that nurses and aides know to look for bruising and bleeding and side effects of an antipsychotic medications.	F 656		
F 684 SS=D	415.11(c)(1) 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684	I. The following corrective actions were accomplished for the residents found to have been affected by the deficient practice: • Resident #38: Medical Director conducted a record review to ensure there were no negative effects from Haldol administration and from delay in lab draw. • RN #1 received a discipline and is	06/24/2021

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F 684	Continued From page 14 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during a Complaint investigation (Complaint #NY00252205) during the Standard survey completed on 04/26/21, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered Care Plan in accordance with physician's orders for two (Residents #38 and 87) of three residents reviewed. Specifically, Resident #38 received intramuscular (IM) Haldol (antipsychotic medication) without a physician's order and staff did not obtain laboratory (lab) work per physician orders for Resident #87. The findings are: 1. Resident #38 was admitted to the facility with diagnoses including dementia, depression, and Parkinson's disease. The Minimum Data Set (MDS-a resident assessment tool) dated 12/18/19 revealed the resident had severely impaired cognition. A facility policy and procedure (P&P) revised 4/21, titled "Medication Administration" documented the following: - Medications shall be administered in a safe and timely manner, and as prescribed. - Medications must be administered in accordance with the orders, including any required time frame. A facility P&P revised 4/21, titled "Medication and Treatment Orders" documented medications	F 684	no longer employed at the facility. • LPN #2 was re-educated that MD order must be obtained prior to administration of any medication • Resident #87: Labs were drawn as ordered on 5/6/21 II. All residents have the potential to be affected by the deficient practice. • All residents with behavioral incidents requiring a prn medication in the past 30 days were reviewed to ensure the medication was administered as ordered. • Facility conducted audit on all residents to identify any residents with missing lab draws in the past 60 days. III. In an effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • Medication Administration policies were reviewed without changes. • Staff Development will provide education to the DON, ADON, all Nursing Supervisors, Unit managers and LPN's on Medication Administration Policies specifically that all medications must be ordered by a MD/NP/PA. • The Laboratory Protocol policy and procedure has been reviewed and revised to include weekly tracking practice. • Staff Development will provide education to all nursing supervisors, unit managers, LPN's and ADON on the updated policy and procedure. • Administrator has secured new contract for laboratory services. IV The facility compliance will be monitored utilizing the following quality assurance system: • Audit tools will be developed to track and ensure timely lab draws. • Audit tool will be developed to	

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F 684	Continued From page 15 shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in the state. Drugs and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the prescriber's last name, credentials, the date and time of the order. The individual receiving the verbal order must write it on the physician's order sheet as a verbal or telephone order. The verbal order will be read back to the practitioner to ensure that the information is clearly understood and correctly transcribed. The practitioner will review and countersign verbal orders during his or her next visit. The Comprehensive Care Plan (CCP) revised 2/03/20 documented Resident #38 wandered and had impaired safety awareness due to dementia. The CCP further documented Resident #38 was the aggressor in a resident to resident altercation throwing a cane at another resident on 2/08/20. The plan was to remove Resident #38 away from other residents during periods of agitation and administer medications as ordered. A Progress Note dated 2/08/20 at 10:30 PM written by Licensed Practical Nurse (LPN) #2 documented staff reported that Resident #38 wandered into other resident rooms, swung a hair dryer, was agitated and yelled at other staff and residents. Resident #38 hit a computer with another resident's cane and threw the cane striking another resident in the chest. Registered Nurse (RN) #1 arrived on the unit and administered Resident #38 intramuscular (IM) medication.	F 684	track behavioral incidents, administration of PRN medications to ensure MD order is present • The DON will audit all behavioral incidents requiring a new prn medication order daily using audit tool to ensure medication was administered as ordered for the three (3) months. • Lab Order report will be audited weekly using audit tool by the Director of Nursing for three (3) months to ensure that all labs are drawn as ordered. • Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results. Responsible Party: Director of Nursing	

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F 684	Continued From page 16 A Progress Note dated 2/09/20 at 8:38 AM written by RN #1, documented at 10:45 PM on 02/08/20, LPN #2 called and stated Resident #38 was throwing papers, books, hitting computers, tearing things off the walls, throwing padlocks, and swinging a blow dryer in another resident's room. The resident grabbed a cane belonging to another resident and threw the cane striking the other resident. The on-call provider was notified and ordered a onetime dose of Ativan (anti-anxiety medication) 2 mg (milligrams) IM. RN #1 further documented that on call Administration was made aware that there was no IM Ativan available and she was instructed by the Assistant Director of Nursing (ADON) to give Resident #38 IM Haldol (antipsychotic). Resident #38 sat in a chair and Haldol was administered. Review of Resident #38's Order Summary Report revealed there was no physician order for IM Ativan or IM Haldol on 2/08/20. During a telephone interview on 4/22/21 at 8:49 AM, RN #1 stated she received a call from LPN #2 that Resident #38 was aggressive, throwing objects at staff and threw a cane at another resident. RN #1 went to the unit to assist LPN #2 and called the on-call provider, who gave a verbal telephone order for Ativan 2 mg IM now. RN #1 delegated LPN #2 to go get the IM Ativan from the emergency box. When LPN #2 arrived back to the unit she informed RN #1 there was no IM Ativan in the facility. RN #1 delegated LPN #2 to call the ADON who was the administrator on call. The ADON stated to LPN #2 to try to get Haldol into Resident #38. RN #1 stated she assumed the ADON stated it was ok to give Haldol instead of the Ativan because the Haldol was available. RN #1 stated she had LPN #2 draw up the IM Haldol 2 mg from the	F 684		

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	335212	A. BUILDING _____ B. WING _____	04/26/2021

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F 684	Continued From page 17 emergency box and RN #1 administered the medication. RN #1 stated she should have called the Nurse Practitioner (NP) back after she discovered there was no IM Ativan to get an order for Haldol which was available. During a telephone interview on 4/22/21 at 12:38 PM, the NP stated RN #1 called her on 02/08/20 and informed her Resident #38 was aggressive and threw a cane at another resident. The NP stated she gave a verbal order for one dose of IM Ativan 2 mg. The RN called back later and stated she gave 2 mg of IM Haldol because IM Ativan was unavailable. The NP stated she told RN #1 administering the Haldol without a physician's order was out of her scope of practice and she should have called her for an order, prior to administering the Haldol. During an interview on 4/22/21 at 3:49 PM, LPN #2 stated she discovered there was no IM Ativan in the emergency box and called the ADON at home for further direction. The ADON stated they had better get some Haldol into the resident and had not directed LPN #2 to call the NP for further orders. LPN #2 stated RN #1 told her to draw up 2 mg of IM Haldol. LPN #2 drew up 2mg IM Haldol from the emergency box, returned to the unit and handed the syringe to RN #1. LPN #2 stated RN # 1 administered the IM Haldol to Resident #38 without a physician's order. During an interview on 4/23/21 at 9:00 AM, the Director of Nursing (DON) stated she was the ADON on 2/08/20 and the administrator on call that night. When LPN #2 called and told her the situation about Resident #38 and that Ativan was unavailable, she told LPN #2 they were going to have to get some Haldol for the resident. The DON stated that they must have	F 684		

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F 684	Continued From page 18 assumed it was ok to give the Haldol. The DON stated RN #1 should have called the NP prior to administering the Haldol to inform her the Ativan was unavailable. The DON stated the RN #1 shouldn't have administered the medication without a physician's order. During a telephone interview on 4/23/21 at 1:55 PM, the Medical Director stated RN #1 should have notified the NP after they identified the Ativan was not available, to obtain an order before giving the Haldol. 2. Resident #87 was admitted to the facility with diagnoses including convulsions (an episode of uncontrolled muscle spasms along with altered consciousness), cirrhosis (chronic disease of the liver), and encephalopathy (brain disease that alters brain function). The Minimum Data Set (MDS- a resident assessment tool) dated 03/24/21 documented the resident had severe cognitive impairment. A facility P&P titled "Laboratory Protocol" dated 4/2021, documented all laboratory tests ordered by the physician are to be obtained timely and results are received with appropriate follow up initiated in a timely manner. When an order is received for a lab test, if the physician does not give a specific date to obtain the specimen, it will be scheduled for the next scheduled lab day. Routine labs will be faxed to the facility and the unit manager/designee will check the results and mark them as received. Review of the Comprehensive Care Plan with a revision date of 4/21/21 revealed no documented focus area or intervention/task related to drawing (obtaining) labs or medication levels as ordered by the physician.	F 684		

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F 684	Continued From page 19 Resident #87's "Medication Review Report," signed by the physician on 4/16/21 documented the following active physician's orders: -Keppra (anticonvulsant medication) level every (Q) 3 months and as needed (PRN) dated 1/10/21. -Obtain admission labs: complete bloood count (CBC), comprehensive metabolic profile (CMP), thyroid stimulating hormone (TSH), HgbA1C (form of hemoglobin linked to sugar in blood), lipid panel (fatty substances in blood), B12, folate (B vitamin), Vit D, ferritin (iron stores in blood) Q 6 months dated 1/10/21. -Topamax (antiepileptic drug used for various types of seizures), Keppra, Clobazam (medication used to treat seizures) level, ammonia (waste level in blood when kidneys or liver are not working properly) level, CBC, CMP and CD4 (type of white blood cell) Q 6 months dated 2/9/21. -Draw CBC, CMP, Serum level, CD4 Count Q 3 months starting on the 24th for 1 day, dated 3/19/21. The "Physician/Prescriber Please Sign and Return" telephone order, dated 2/9/21 signed by the physician, documented a CBC, CMP, U/A (urinalysis), ammonia level "now" and Q 6 months. The physician visit note dated 2/9/21 documented chronic encephalopathy, history of seizure disorder, multiple other problems and they would obtain blood work including drug levels and ammonia level. The physician acute visit note dated 3/19/21 documented the resident had a history of seizure disorder, they would update some blood work and depending on the results they would	F 684		

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F 684	Continued From page 20 decide on further treatment. Review of nursing Progress Notes dated 2/9/21 at 10:20 AM documented Resident #87 was seen and examined by the Medical Doctor (MD) for an acute visit. New orders included Topamax, Keppra, clobazam level Q 6 months, CBC, CMP, UA/C&S (culture and sensitivity) "now" and Q 6 months. CD4 count Q 6 months, ammonia level "now" and Q 6 months. Review of nursing Progress Notes dated 1/10/21 through 4/26/21 revealed no documented evidence labs were obtained as ordered by the physician. Review of Resident #87's electronic medical record (EMR) including interdisciplinary Progress Notes, provider notes, and the lab results section from 1/2021 through 4/26/21 revealed no documented evidence labs were drawn/resulted as ordered by the physician. Lab work results for Resident #87 from January 2021 through April 2021 were requested by the surveyor and no documented evidence of lab work was provided by the facility. During an interview on 4/26/21 at 11:50 AM, the Director of Nursing (DON) stated the previous DON had changed lab contracts recently and there was no technician provided by the lab to draw (obtain) resident's ordered lab work, so the facility staff was responsible for obtaining lab work as ordered by the physician. The DON stated the facility census was building back up and there were a lot of issues with the current lab. She stated she was aware of the issue with labs and the facility was in the process of developing a new system for labs to be drawn. Additionally, the DON reviewed Resident #87's	F 684		

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F 684	Continued From page 21 EMR and stated she didn't see any lab results available. During an interview on 4/26/21 at 12:14 PM, the Licensed Practical Nurse (LPN) #4 Unit Manager (UM) stated labs get ordered on admission and when the physician completed rounds. If labs were ordered, the expectation is that they are to be drawn. She stated the process for lab draws was a work in progress because the facility went without a lab contract for months. She stated no one was drawing routine labs and that they had a contract with the hospital, but the hospital wasn't sending a technician to draw the labs so they were responsible to draw their own. LPN #4 UM stated Resident #87 did have labs drawn but there was always an issue with the lab, they weren't labelled right or not enough tubes were used. LPN #4 UM reviewed Resident #87's EMR and stated she didn't see any lab results for the resident at all and that they should have been done.	F 684		
F 693 SS=D	415.12 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693	I. The following corrective actions were accomplished for the residents found to have been affected by the deficient practice: • Resident #58: Nutrition Assessment was completed by RD on 4/27/21 • Resident #58: Weight was obtained on 4/19/21 and 4/26/21 II All residents have the potential to be affected by the deficient practice. • All resident's receiving tube feeding were reviewed to ensure initial and at least quarterly nutrition assessments were completed in the last 3 months. • All residents were reviewed to	06/24/2021

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F 693	Continued From page 22 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review conducted during the Standard survey, completed on 4/26/21, the facility did not ensure that a resident who is fed by enteral means (method of feeding that uses the gastrointestinal (GI) tract to deliver part or all of a person's caloric requirements) receives the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #58) of one resident reviewed for feeding tubes. Specifically, there was a lack of an initial nutritional assessment and reassessment to assure residents nutritional needs were being met. Additionally, there was a lack of monitoring residents' weight. The finding is: Review of a facility policy and procedure titled "Enteral Feeding" with revision date of 4/2021 documented the interdisciplinary team, including the Dietitian, will conduct a full nutritional assessment within current initial assessment timeframes to determine the clinical necessity of enteral feedings. The assessment will include evaluation of the resident's current nutritional status and evaluation of the resident's current	F 693	identify and ensure all residents have an initial and/or at least quarterly nutrition assessment. • All residents were assessed to ensure weights have been obtained per facility policy. III. In an effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • The facility has hired a new dietitian who was educated on the facility policy and procedure for nutrition assessment completion and tube feeding monitoring • Tube Feeding, Nutrition assessment and weight policies were reviewed without revisions. • The Staff Educator will reeducate the DON, ADON, Unit Managers, Director of Food Services and Dietitian on tube feeding, weight (tracking/monitoring), and nutrition assessment policies • Staff Education will educate all CNA and LPNs on facility weight policy and procedure including obtaining and recording weights IV. The facility compliance will be monitored utilizing the following quality assurance system: • An audit tool will be developed to track and monitor nutrition assessments and resident weights per facility policy. • All residents, including those receiving tube feeding, will be audited weekly by the Director of Nursing for three (3) months and then quarterly for the next 12 months using the audit tool to ensure that resident weights have been obtained/recorded and nutrition assessments have been completed per	

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F 693	Continued From page 23 clinical status. The recommendation to initiate the use of a feeding will be based on the results of the comprehensive nutritional assessment, and will be consistent with current standards of practice, the resident's advance directives, treatment goals and facility policies. The Dietitian, with input from the Physician and Nurse, will estimate calorie, protein, nutrient, and fluid needs; determine whether the resident's current intake is adequate to meet his/her nutritional needs; recommend special food formulations and calculate fluids to be provided (beyond free fluids in formula). 1. Resident #58 had diagnoses which include hemiplegia (paralysis on one side of body) and hemiparesis (weakness of one side of the body) following cerebral infarct, diabetes mellitus type 2, dysphagia (difficulty swallowing), and aphasia (absence or difficulty with speech). Review of the Minimum Data Set (MDS - a resident assessment tool) dated 3/13/21 revealed resident is severely cognitively impaired. During observations of Resident #58 on 4/20/21 at 10:59 AM, 4/21/21 at 10:00 AM, and 4/22/21 11:25 AM revealed Glucerna 1.5 running at a rate of 30 ml/hour continuous. Review of the Order Summary Report dated 4/23/21 revealed current feed tube order Glucerna (nutritional supplement) 1.5- give 30 milliliters(ml) per hour via G-tube (gastrostomy tube) every shift for nourishment. To run continuously. Flush PEG (percutaneous endoscopic gastrostomy- a surgical procedure for placing a feeding tube without having to perform an open operation on the abdomen)-tube every 4 hours with 100ml water every 4 hours. Liquid protein 30ml via PEG-tube one time a day for skin integrity. Check weekly	F 693	facility policy. • Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit result Responsible Party: Director of Nursing	

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F 693	Continued From page 24 weight every day shift every Monday for nutritional monitoring. Review of untitled comprehensive care plan with date initiated of 4/19/21 revealed the resident requires tube feeding related to dysphagia. Goal to maintain adequate nutritional and hydration status as evidenced by stable weight and no signs or symptoms of malnutrition or dehydration. No nutritional interventions noted. Review of Medication Administration Record (MAR) dated 1/29/21 through 3/10/2021 revealed resident received Jevity 1.5 Cal (calorie) Liquid (Nutritional Supplements). Give 55 ml via G-Tube every 24 hours for nourishment to run until Jevity 1.2 available. 3/10/21 through 4/16/21 feed was changed to Glucerna 1.5 Cal Liquid (nutritional Supplements). Give 55ml/hour via G-Tube every shift to run continuously. 4/16/21 through 4/22/21 feed was changed to Glucerna 1.5 Cal Liquid (nutritional Supplements). Give 30ml/hour via G-Tube every shift to run continuously. Review of Order Summary Report dated 4/23/21 revealed check weekly weight every day shift every Monday for Nutritional Monitoring starting 1/29/21. Review of Progress Notes between 1/29/21 through 4/21/21 reveals no nutritional assessments completed. In addition, no weights noted. During an interview on 4/21/21 at 3.00 PM. the Administrator stated he was aware of an issue with timely weights for residents and plans to bring the issue to QA. Additionally, the Administrator stated the prior RD worked for the facility from 8/28/20 through 4/15/21. However,	F 693		

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F 693	Continued From page 25 he initially was present at the facility but then moved to Florida and continued working for the facility remotely with a contract company. The Administrator stated he was not aware the nutritional assessments were not completed as required. During an interview on 4/22/21 at 11:30 AM, the Food Service Director (FSD) stated she never saw the previous Dietitian and couldn't say how long he was employed at the facility. To her knowledge he was never at the facility. During an interview on 4/23/21 at 9:20 AM, the Minimum Data Set (MDS) Registered Nurse (RN) stated there was an issue with the prior RD completing assessments either late or not completing assessments at all. That is why we have a new one now. During an interview on 4/26/21 at 12:40 PM, the Consultant Registered Dietitian stated she just started on the job on 4/16/21. The assessments are very behind from the last RD's appointment. The RD stated Resident #58 should have had an initial assessment completed a long time ago and reassessed with all the tube feed changes. The RD stated they had not completed an assessment on Resident #58.	F 693		
F 836 SS=C	415.12(g)(2) 483.70(a)-(c) License/Comply w/ Fed/State/Locl Law/Prof Std §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in	F 836	The following corrective actions were accomplished for the residents found to have been affected by the deficient practice: • There were no adverse effects to residents resulting from the lack of Carbon Monoxide detection. • Director of Environmental Services was educated on the International Fire Code, Section 915 Carbon Monoxide	06/24/2021

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F 836	Continued From page 26 compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review during the Standard survey completed on 4/26/21, the facility did not operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes. Specifically, the facility was not in compliance with section 915 of the 2015 edition of the International Fire Code, as adopted by New York State, which requires carbon monoxide detection in buildings with fuel-burning appliances. This affected five (Canal View, Garden View, Orchard View, Autumn View	F 836	Detection, and the requirements for placement of the Carbon Monoxide Detectors. • The local building code enforcement official has inspected and is confirming the location of the Carbon Monoxide Detectors which have been installed between each source of gas and resident area. • II. All residents have the potential to be affected by the deficient practice. • Staff Development will educate all facility staff on responding to a Carbon Monoxide activation. III. In effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • Policy and procedure for responding to a Carbon Monoxide activation will be added to orientation process and annual mandatories. • The Director of Environmental Service will monitor carbon monoxide detectors monthly conduct random carbon monoxide drill (one per shift per quarter for 12 months). IV. The facility compliance will be monitored utilizing the following quality assurance system: • An audit tool will be developed to track CO detector testing and drills • The Director of Environmental Services will report, on a quarterly basis, the number of CO drills and CO detector testing/monitoring results, along with action (s) taken and the effectiveness of action(s) that may have been taken to the Facility-	

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F 836	Continued From page 27 North, Autumn View South) of five resident units. The finding is: Review of the facility's Emergency Preparedness Plan, revised 4/2021, revealed a document called, "Carbon Monoxide Alarm Activation". According to this document, carbon monoxide alarms are located in areas of the building where devices or appliances are located that could be a potential source of carbon monoxide, and these alarms provide an audible alarm from the detector itself, not connected or part of the building's fire alarm system. Observation throughout the facility on 4/19/21 from 9:55 AM until 12:30 PM revealed the facility was a one-story building with a partial basement and a penthouse. Further observation revealed carbon monoxide detection was not installed on resident units, in the main corridor, the service corridor, the kitchen, the laundry room, or the partial basement. Additional observation during this time revealed fuel-burning devices were located in the facility's two boiler rooms, in the kitchen, and in the laundry room, which were all located on the main floor, off of the facility's main corridor and service corridor. During an interview on 4/19/21 at 12:00 PM, the Director of Environmental Services stated he was not aware of any stand-alone carbon monoxide detectors in the facility, but facility's fire alarm system may be equipped with carbon monoxide detection. Review of an outside contractor's fire alarm system inspection reports dated 10/7/20 and 3/23/21 revealed both reports listed all fire alarm system devices separately and carbon monoxide detectors did not appear on either list.	F 836	wide QAPI Committee for their review, guidance, and continued direction. Responsible Party: Director of Environmental Services	

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	335212	A. BUILDING _____ B. WING _____	04/26/2021

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F 836	Continued From page 28 During an interview on 4/22/21 at 10:15 AM, the Director of Environmental Services stated the outside contractor who inspected the fire alarm system advised the system did not contain carbon monoxide detection and the facility has no stand-alone carbon monoxide detectors. The Director of Environmental Services added that the facility's fuel burning devices are located in two boiler rooms, the kitchen and the laundry room. 42 CFR 483.70(b) 10NYCRR: 415 29(a)(2), 711.2(a)(1) 2015 International Fire Code, Section 915,1103.9 2017 New York State Supplement to the 2015 International Fire Code: 915, 1103.9, 915.2 .1, 915.2.3.3.2.3	F 836		

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R 722 SS=D	402.6(d) Criminal History Record Check Process Section 402.6 Criminal History Record Check Process. ..... (d) A provider may temporarily approve a prospective employee while the results of the criminal history record check are pending. The provider shall implement the supervision requirements identified in section 402.4 of this Part, applicable to the provider, during the period of temporary employment. This LICENSURE is not met as evidenced by: Based on interview and record review during the Standard survey completed on 4/26/21, the facility lacked documented evidence of supervision of an employee who was subject to the New York State Department of Health Criminal History Record Check (CHRC) program, during the time that the CHRC review was pending. This affected one (Employee #1) of six personnel files reviewed for compliance with CHRC regulations. The finding is: Review of the facility's undated policy and procedure called, "Criminal Background Check" revealed between the times fingerprinting is scheduled and an approved application is returned, the applicant will be supervised at all times and a supervisor form will be completed for each shift worked and filed separately in a secured identified binder Review of the personnel file for Employee #1 (Agency Certified Nurse Aide, CNA) revealed the file contained no record of supervision while awaiting CHRC results. Review of the facility	R 722	I. The following corrective actions were accomplished for the residents found to have been affected by the deficient practice: • There were no adverse effects to residents resulting from the lack of supervision for CNA #1. II. All residents have the potential to be affected by the deficient practice. • The Director of Human Resources has reviewed all employees hired in the last 30 days to ensure supervision sheets have been received. III. In effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • The Policy and procedure for new hire specifically employee supervision prior to CHRC clearance was reviewed with the Director of Human Resources without changes. • Staff Development will provide education to the Director of Human Resources as well as all facility department heads and supervisors on ensuring supervision sheets are completed for all new hires not cleared through CHRC. I. The facility compliance will be monitored utilizing the following quality assurance system: • An audit tool will be developed to track supervision compliance for new hires. • The Director of Human Resources will conduct audit all new hires weekly for supervision sheets. • The Director of Human Resources will report, on a monthly basis, the results, along with action(s) taken and the effectiveness of action(s) that may have	06/24/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	05/21/2021

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R 722	Continued From page 1 schedule revealed Employee #1 was hired on 1/8/21, and worked eleven shifts from 1/8/21 until 1/23/21, all 10:00 PM to 6:00 AM. CHRC issued a determination letter for Employee #1 on 1/28/21. During an interview on 4/20/21 at 1:40 PM, the Human Resources Director (CHRC Authorized Person) stated there were no supervision sheets filled out for Employee #1. Additionally, the Human Resources Director stated stated she normally does the supervision for agency personnel and fills out the supervision form on a daily basis, but for Employee #1, it was missed because it was a very hectic time. The Human Resources Director stated at that time, she had many duties other than CHRC, which divided her time and attention, but since then, the other duties have been reassigned, and she can focus on CHRC and Human Resources. 402.4 402.4(b)(2)(i) 402.6(d)	R 722	been taken to the Facility-wide QAPI Committee for their review, guidance, and continued direction. Responsible Party: Director of Human Resources	
I210 SS=D	415.19 Infection Control This LICENSURE is not met as evidenced by: Based on interview and record review during the Standard survey completed on 4/26/21, 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. Specifically, Legionella culture sampling and analysis was not conducted annually. This affected five (Canal View, Garden View, Orchard View, Autumn View	I210	I. The following corrective actions were accomplished for the residents found to have been affected by the deficient practice: • There were no adverse effects to residents resulting from the lack of Legionella Testing. • Legionella testing was performed on 5/3/2021. Results from all areas returned negative on 5/5/2021. • There were no adverse effects to residents resulting from the lack of employee influenza or pneumococcal vaccinations II. All residents have the potential to be affected by the deficient practice. • Residents will be assessed for	06/24/2021

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I210	Continued From page 2 North, Autumn View South) of five resident units. Additionally, the facility did not maintain an Infection Control Program to help prevent the development and transmission of disease for ten (employees 1, 2, 3 4, 5, 6, 7, 8, 9 and 10) of 10 employees reviewed. Specifically, the facility did not provide evidence that education was provided to its employees on the risks and benefits of the Influenza and Pneumococcal vaccine and employees were not offered both vaccines. The finding is: According to the New York State Department of Health's Health Advisory called, "Regulation for the Protection Against Legionella" dated 8/12/16, Part 4 of the New York State Sanitary Code Protection Against Legionella, became effective on July 6, 2016. Subpart 4-2 of the regulations require all general hospitals and residential health care facilities to adopt and implement a Legionella culture sampling and management plan for their potable water systems that shall include a schedule to conduct routine Legionella culture sampling and analysis at intervals not to exceed 90 days in the first year and annually thereafter. 1. Review of the facility policy called, "Legionnaires Disease Infection Control and Monitoring Policy", revised 10/1/20, revealed when a Legionellosis case has been confirmed and identified as healthcare-associated, water sampling will be conducted from potential sources, such as resident room faucets, shower rooms, and hot water tanks. Review of the collection of the facility's Legionella documents, located in the Director of Environmental Service's binder revealed	I210	exposure to Legionella and other opportunistic pathogens, specifically vital signs and respiratory assessment. • Influenza Vaccination doses for the 2021-2022 Influenza season were ordered on February 19, 2021. • Staff development will educate and offer Pneumococcal vaccinations to all staff and provide documentation validating education, vaccination administration or declination. • Staff development will educate and offer influenza vaccinations – during flu season and provide documentation validating education, vaccination administration or declination. III. In effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • Infection Control Plan was reviewed without changes. • Staff Development will provide education to the Director of Human Resources, Director of Nursing and Assistant Director of Nursing on the facility policy/procedure for pneumococcal and influenza vaccinations including education on the risks and benefits of vaccinations, which includes offering pneumococcal vaccinations on hire, and annually if declined, as well as offering influenza vaccinations during flu season. • Facility water management plan and legionella testing policy was reviewed with the Director of Environmental services without changes • Staff Development will provide education to the Director of Environmental Services on the facility's water management plan policy and procedure including responsibility to ensure annual	

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I210	Continued From page 3 Legionella water sampling was completed on 1/2/20 and there was no documentation of water sampling since that date. During an interview on 4/22/21 at 3:15 PM, the Administrator stated in January of 2020, a company out of Pennsylvania tested the facility's water for Legionella, and since then, a new local company has been identified to do this testing going forward, but testing has not occurred since January of 2020. The Administrator added that annual Legionella testing is a regulation, therefore it is not listed in the facility's Legionella policy. 2. Review of the facility policy and procedure (P&P) titled "Infection Prevention and Control" dated 3/2021 documented all staff will be offered the influenza vaccine from October of each year through the end of March the following year, informed consent in the form of a decision regarding the risks and benefits of the vaccination will occur prior to the vaccination and a consent will be signed prior to administration or declination form will be signed. The P&P documented all staff's pneumococcal immunization status will be determined upon hire and will be documented in the staff's immunization record. All staff with undocumented or unknown pneumococcal vaccination status will be offered the vaccine. Informed consent in the form of a decision regarding the risks and benefits of the vaccination will occur prior to the vaccination and a consent will be signed prior to administration or declination form will be signed. Upon request on 4/21/21 and through the duration of the survey the facility could not provide any documented evidence staff were offered or were educated on the influenza or	I210	Legionella culture sampling, testing and analysis has been completed and results submitted to the administrator. IV. The facility compliance will be monitored utilizing the following quality assurance system: • The Director of Environmental Services will report a review of the Legionella testing and water management plan and verification of annual completion of the legionella sampling/testing and results to the QA quarterly. • An audit tool will be developed to track pneumococcal and influenza vaccination education, administration and/or declination. • The Influenza vaccination plan review will be added to the monthly QA schedule for verification of the status in supply delivery and plan for staff inoculation. • The Director of Nursing will audit all staff monthly for the next 12 months for evidence of pneumonia and influenza vaccination education, administration and/or declination status. • Frequency of on-going audits will be determined by the QA Committee based on audit result Responsible Party: Administrator	

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I210	Continued From page 4 pneumococcal vaccines for employees 1 through 10. During an interview on 4/21/21 at 12:45 PM, the Director of Nursing (DON) stated most employees did not receive the flu shot due to (d/t) a shortage of the vaccine. The DON also notified the facilities cooperate headquarters regarding ordering more influenza vaccine but received no response in October of 2020. During an interview on 4/22/21 at 8:50 AM, the DON stated the pneumococcal vaccine was not offered to the employees. During an interview on 4/26/21 at 11:55 AM, the Administrator stated they recognized and identified in February of this year the facility needed to improve on getting the influenza and pneumococcal vaccine for both residents and staff so they don't run into the same situation next year. 415.19.(a)(1) 4-2.4(a)(2)	I210		

Accepted with revisions 05/21/2021 RM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2021
FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS Due to the COVID-19 Public Health Emergency, changes in facility operations may require surveyors to adjust standard Physical Environment (PE) and Life Safety Code (LSC) survey procedures. Adjustments to PE and LSC survey procedures are listed below. These adjustments are intended only for the PE and LSC portion of a survey and not intended to alter or modify the health portion of a survey. According to the State Operations Manual (SOM) Appendix I, Table 1, "Sample Size of Resident/Patient Rooms". A facility with 60-80 bedrooms, dictate 52-66 rooms be checked for PE and LSC standards. During the LSC survey at Villages of Orleans from 4/19/21 to 4/22/21, 33 of the 67 resident rooms were inspected by the Surveyor. The number of resident rooms inspected was lower than the requirement because several rooms were identified as precautions rooms.	K 000		
K 111 SS=E	QSO-20-31 NFPA 101 Building Rehabilitation Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 13 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies	K 111	1. Orange expanding foam was removed from the barrier wall between lobby and administration wing, areas above the 2006 addition and areas around the insulated pipes and replaced with NFPA healthcare compliant firestop. 2. The Director of Environmental Services and maintenance staff will be educated that all fire barrier walls must have at least a two hour fire resistance rating and any penetrations must be properly sealed with NFPA healthcare compliant firestop. 3. An audit/visual inspection of all facility fire barrier walls and areas of recent	06/24/2021

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

Electronically Signed | 05/21/2021

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K 111	Continued From page 1 with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This STANDARD is not met as evidenced by: Based on observation, interview, and record review during the Life Safety Code survey completed on 4/26/21, fire barriers that separated distinct construction types were not properly maintained. Specifically, fire barrier walls were not designed to have at least a two-hour fire resistance rating due to the presence of an non-fire rated material. This affected two (fire barrier between the existing building and the 2006 addition and the fire barrier between the Lobby and the Administrative Wing) of four fire barriers. The finding is: 1. a) Observation above the Lobby ceiling tile of the fire barrier wall between the Lobby and the	K 111	renovation/construction, as is reasonably possible will be completed by 5/21/2021 and make any necessary repairs within 30 days of the inspection. 4. The Director of Environmental Services and maintenance staff will be educated on proper use and identification of NFPA healthcare compliant fire stop products to seal fire/smoke barrier penetrations. 5. The Director of Environmental Services and has initiated a quarterly inspection of all fire barrier walls to identify any areas where the orange expanding foam was used and/or penetrations and make necessary replacements with NFPA healthcare compliant firestop. 6. The Director of Environmental Services will provide quarterly reports on all inspections to the QAPI committee for the next 12 months. The QAPI Committee will review this plan, audit the effectiveness of the action, offer guidance and continued education. The Director of Environmental Services is responsible for this plan.	

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K 111	Continued From page 2 Administrative Wing on 4/21/21 at 8:50 AM revealed several areas of orange expanding foam along the fire barrier. Continued observation revealed the largest area of orange expanding foam measured eight inches high by four inches wide. At the time of the observation, the Director of Environmental Services stated he did not apply the expanding foam, he did not know who applied it or why, and he did not know when the expanding foam was applied. The Director of Environmental Services also stated he did not know the name of the product and did not have a container of it to check the label for fire resistance rating information or to see if the label said the product was approved for use in healthcare occupancies. A review of the facility's floor plan at the time of this observation revealed this was a fire barrier wall. b) Observation above the 2006 addition ceiling tile of the fire barrier wall between the 2006 addition and the existing building on 4/21/21 at 9:20 AM revealed several areas of orange expanding foam along the fire barrier. Continued observation revealed the orange expanding foam was applied around the bottom of three six-inch insulated pipes, in an area that measured nine inches long by four inches wide. Another area of orange expanding foam was applied around the top of another six-inch insulated pipe, in an area that measured six inches wide by two inches high. A review of the facility's floor plan at the time of this observation revealed this was a fire barrier wall. During an interview on 4/22/21 at 10:05 AM, the Director of Environmental Services stated smoke barriers and fire barriers are audited monthly. Review of the audit form called "Smoke/ Fire	K 111		

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K 111	Continued From page 3 Barrier Walls Audit" revealed the most recent audit was done on 3/11/21 and no issues or comments about orange expanding foam were noted on the form. During an interview on 4/22/21 at 4:00 PM, the Administrator stated the facility performed corrective work on the fire barriers in September 2020 as part of a plan of correction from the last Life Safety Code survey, and the orange expanding foam was not used as part of the corrective work. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 8.3, 8.3.1, 8.3.1.2	K 111		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321	1. Orchard Soiled Utility Room: Self-closing hardware was ordered, and installation will be completed by June 24, 2021. 2. An audit of all hazardous area doors will be conducted to ensure they self-close and latch into their door frames. 3. The Director of Environmental Services, environmental services staff and maintenance staff will be educated that hazardous area doors must self-close and latch into their frames. 4. The Director of Environmental Services will include audit/inspection of all hazardous area doors on quarterly facility door inspection/audit tool. 5. The Director of Environmental Services will provide quarterly reports on all audit/inspections including audit of hazardous area doors to ensure they self-close and latch into their frames, to the QAPI committee for the next 12 months. The QAPI Committee will review this plan, audit the effectiveness of the action, offer guidance and continued education.	06/24/2021

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K 321	Continued From page 4 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 4/26/21, hazardous areas were not protected. Issues include a corridor door protecting a hazardous area did not self-close and latch into its door frame. This affected two (Canal View and Orchard View) of five resident units. The findings are: Observation on the Orchard View Unit on 4/19/21 at 10:30 AM revealed the corridor door of the Soiled Utility Room would not self-close and latch into its door frame. Further observation revealed the inner door handle was pointing in a downward position and the latch was stuck inside the door. Continued observation revealed the room was greater than 50 square feet in size and was being used to store garbage, soiled linen, and medical waste. During an interview at the time of the observation, the Director of Environmental Services stated the door handle was replaced within the last month and needed to be tightened. During an interview on 4/22/21 at 2:50 PM, the Director of Environmental Services stated he audits all facility doors periodically, but only documents the audits of the smoke and fire	K 321	The Director of Environmental Services is responsible for this plan.	

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	335212	A. BUILDING 01 - 1960 BLDG. B. WING _____	04/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 5 barrier doors. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.3.2.1	K 321		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363	1. Copy room door latch was repaired on 5/3/2021 2. Autumn view South Resident #231 room door latch was repaired on 5/3/2021 3. Garden view Resident #11 room door latch was repaired on 5/3/2021 4. An audit of all facility corridor doors to ensure they latch closed into their door frames will be completed by 6/24/2021 5. The Director of Environmental services, environmental services staff and maintenance staff will be educated that corridor doors are to be latched closed into their door frames. 6. Quarterly Fire and Annual Door Audit/Inspection tool has been instituted which includes inspection to ensure corridor doors latch closed into their door frames. 7. The Director of Environmental Services will provide Quarterly Fire and Annual Door Audit/Inspection reports, which includes inspection to ensure corridor doors latch closed into their door frames, to the QAPI committee for the next 12 months. The QAPI Committee will review this plan, audit the effectiveness of the action, offer guidance and continued education. The Director of Environmental Services is responsible for this plan.	06/24/2021

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K 363	Continued From page 6 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 4/26/21, doors protecting corridor openings were not properly maintained to resist the passage of smoke. Issues included, corridor doors could not be latched closed into their door frames. This affected three (Canal View, Autumn View South and Garden View) of five resident units and one of one Administrative Wing. The findings are: 1.a) Observation in the Administrative Wing on 4/19/21 at 12:20 PM revealed the corridor door of the Copy Room would not latch into its door frame. b) Observation in the Autumn View South Unit on 4/20/21 at 2:35 PM revealed the corridor door of Resident Room #231 would not latch into its door frame. c) Observation in the Garden View Unit on 4/20/21 at 3:35 PM revealed the corridor door of Resident Room #11 would not latch into its door frame. During an interview on 4/20/21 at 3:35 PM, the Director of Environmental Services stated the door frames were painted about two weeks ago and the extra layer paint on the doorframe cushions is probably preventing the door from latching. During an interview on 4/22/21 at 2:50 PM, the	K 363		

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K 363	Continued From page 7 Director of Environmental Services stated he audits all facility doors periodically, but only documents the audits of the smoke and fire barrier doors. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.6.3, 19.3.6.3.1, 19.3.6.3.5	K 363		
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation, interview, and record review during the Life Safety Code survey completed on 4/26/21, smoke barrier walls were not properly maintained. Issues included smoke barriers were not complete from floor to roof deck, not designed to have at least a 30-minute fire resistance rating, and not designed to be resistant to the passage of smoke due to unsealed penetrations. This affected two (Autumn View North and Autumn View South) of five resident units. The finding is:	K 372	1. Lobby/Autumn view south 3x2" penetration was sealed with NFPA healthcare compliant firestop caulk 2. Autumn view north 1" diameter penetration was sealed with NFPA compliant fire stop caulk 3. An audit/inspection of all facility smoke barriers, floor to roof deck, will be conducted by 6/24/21 as is reasonably possible to ensure at least a 30-minute fire resistance rating, and resistant to the passage of smoke. Any unsealed or any necessary repairs will be made within 30 days of the inspection. with NFPA healthcare compliant firestop material. 4. The Director of Environmental Services and maintenance staff will be educated that all facility smoke barriers, floor to roof deck must have a 30-minute fire resistance rating and resistant to the passage of smoke. 5. The Director of Environmental Services and maintenance staff will be educated on proper use and identification of NFPA healthcare compliant fire stop products to seal fire/smoke barrier penetrations 6. The Director of Environmental Services has initiated a quarterly audit/inspection all facility smoke barriers, floor to roof deck to identify any areas of penetration and seal with NFPA compliant fire stop material. 7. The Director of Environmental	06/24/2021

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K 372	Continued From page 8 1. a) Observation above the corridor ceiling tiles in the Lobby on 4/21/21 at 9:05 AM revealed an approximate three-inch high by two-inch wide unsealed penetration through the smoke barrier wall that separated the Lobby from the Autumn View South Unit. Further observation revealed this penetration was filled with mineral wool that was not sealed with a fire rated material. A review of the facility's floor plan, at the time of this observation, confirmed this was a smoke barrier wall. b) Observation above the corridor ceiling tiles in the Autumn View North Unit on 4/21/21 at 9:10 AM revealed an approximate one-inch diameter unsealed penetration through the smoke barrier wall that separated Autumn View North from Autumn View South. Further observation revealed one cut white wire installed through the penetration. During an interview at the time of this observation the Director of Environmental Services stated he was unsure what the white wire was or how long the penetration had been there. During an interview on 4/22/21 at 10:05 AM, the Director of Environmental Services stated smoke and fire barrier walls are audited monthly. He further stated he personally did the two most recent audits and was not aware of any recent work done on the Autumn View smoke barriers. Review of the audit form titled "Smoke/ Fire Barrier Walls Audit" revealed the most recent audit was completed on 3/11/21 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.3.7.3, 8.5, 8.5.1, 8.5.2, 8.5.2.1, 8.5.2.2, 8.5.2.3	K 372	Services will provide quarterly reports on inspections of all facility smoke barriers, floor to roof deck, identifying any areas of penetration and sealed with NFPA compliant fire stop material to the QAPI committee for the next 12 months. The QAPI Committee will review this plan, audit the effectiveness of the action, offer guidance and continued education. The Director of Environmental Services is responsible for this plan.	
K 521 SS=E	NFPA 101 HVAC	K 521	1. Fire Dampers #29, #32 and #33 repair has been scheduled to be completed	06/24/2021

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K 521	Continued From page 9 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on interview and record review during the Life Safety Code survey completed on 4/26/21, fire dampers were not properly maintained. Specifically, fire dampers that failed inspection and testing were not repaired or replaced. This affected one of one Penthouse. The finding is: Review of an outside contractor's Damper Inspection History Report dated 1/30/19 revealed the outside contractor inspected and tested 43 fire and smoke dampers throughout the facility on 1/8/19. Further review revealed fire damper #29, #32, and #33 were all located in the Penthouse and were all documented as "Fail" on 1/8/19. The deficiency report for #29 and #32 was documented as, "New damper required" and the deficiency report for #33 was documented as, "Two new dampers required". A review of the facility floor plan layout revealed the Penthouse walls were located along a fire barrier. During an interview on 4/22/21 at 2:55 PM, the Director of Environmental Services stated the outside contractor was last at the facility in 2019 and he has no documentation that show the dampers that failed in 2019 were repaired or replaced.	K 521	by local vendor on 5/3/2021 2. An audit/inspection of all facility fire dampers inspection reports were audited to ensure no other dampers have failed inspection. 3. An audit/inspection and testing of all fire dampers has been scheduled through a local vendor to ensure all fire dampers are in proper working order and to make any necessary repairs. 4. The director of environmental services and maintenance staff will be educated to ensure all fire damper inspection reports are reviewed to ensure any recommended repairs are made timely. 5. Fire damper inspection reports will be submitted directly to the administrator. 6. The Director of Environmental Services will provide quarterly reports on all fire damper inspections to the QAPI committee for the next 12 months. The QAPI Committee will review this plan, audit the effectiveness of the action, offer guidance and continued education. The Director of Environmental Services is responsible for this plan.	

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K 521	Continued From page 10 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.1.1.4.1.1, 8.3.3, Table 8.3.4.2 2010 NFPA 80: 19.4, 19.4.1, 19.4.1.1, 19.5, 19.5.3, 19.5.4	K 521		
K 923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold	K 923	1. Oxygen cylinders from Garden View and Orchard View Clean Utility rooms and vacant resident #201 were removed and placed in facility specified/designated oxygen storage room with appropriate oxygen storage signage was already affixed on door. 2. An audit was conducted of the facility to ensure 'no smoking/no open flame/oxygen in use' signage was properly posted on facility designated oxygen storage areas. 3. An audit was conducted to ensure oxygen cylinders, not in use, were stored only in rooms the facility has designated as oxygen storage rooms and appropriate signage on doors was present. 4. Staff development educated all nursing, therapy, and environmental staff that oxygen is to be stored in rooms the facility has designated as oxygen storage rooms. 5. Environmental Services staff will visually inspect all utility rooms and resident rooms to ensure oxygen is not stored inappropriately and oxygen signage is properly posted designated oxygen storage rooms daily for the next 3 months. 6. The Director of Environmental Services will provide monthly reports on all inspections including oxygen storage and signage to the QAPI committee for the next 3 months. The QAPI Committee will review this plan, audit the effectiveness of the action, offer guidance and continued education. The Director of Environmental Services is	06/24/2021

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K 923	Continued From page 11 pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 4/26 /21, oxygen storage areas were not maintained. Specifically, signage stating that oxygen was stored within a room was not present. This affected three (Garden View, Orchard View, and Autumn View South) of five resident units. The finding is: 1. a) Observation on the Garden View Unit on 4/19/21 at 10:20 AM, revealed one E-sized oxygen cylinder was stored in a wheeled cart in the Clean Utility Room. A second observation of an E-sized oxygen cylinder in this room was made on 4/21/21 at 9:45 AM. The door to the Clean Utility Room was not equipped with a sign stating ""CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". b) Observation on the Orchard View Unit on 4/19/21 at 10:25 AM, revealed two E-sized oxygen cylinders were stored in wheeled carts in the Clean Utility Room. A second observation of two E-sized oxygen cylinders in this room was made on 4/21/21 at 9:50 AM. The door to the Clean Utility Room was not equipped with a sign stating ""CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". During an interview on 4/21/22 at 9:45 AM, the Assistant Director of Nursing stated oxygen is not normally stored in the Clean Utility Room,	K 923	responsible for this plan.	

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K 923	Continued From page 12 but is usually stored in the Oxygen Storage Room on the Canal View Unit, and he was unsure why oxygen was stored in a Clean Utility Room. c) Observation on the Autumn View South Unit on 4/20/21 at 2:20 PM revealed one E-sized oxygen cylinder was stored in a wheeled cart inside Resident Room 201. Further observation revealed Resident Room 201 was a vacant private room and the corridor door was not equipped with a sign stating ""CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". During an interview at the time of this observation, the Director of Environmental Services stated this room has been vacant for about one week and he is not sure how long the oxygen cylinder has been stored in this room. He also stated the cylinder should be stored in the Oxygen Storage Room on the Canal View Unit. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.3.2.4 2012 NFPA 99: 11.3.4, 11.3.4.1, 11.3.4.2	K 923		

EXHIBIT 41

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F 000	INITIAL COMMENTS A Recertification and Complaint Investigation Survey, ACTS reference #'s (NY00268730, NY00277988, NY00278907, NY00278889, NY00279688 NY00283507) was conducted at The Villages of Orleans Health and Rehab Center 10.18.21 through 10.25.21 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey. 42 CFR Part 483.10 Resident Rights 42 CFR Part 483.25 Quality of Care - accidents	F 000		
F 578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578	I. The following corrective actions were accomplished for the resident found to have been affected by the deficient practice: • Resident # 18 and #24 MOLST forms were reviewed and orders placed in PCC to reflect choices to not have labs, vital signs and/or weights obtained. II. All residents that have the potential to be affected by the deficient practice. • The following corrective actions will be taken: • MOLST forms for comfort care were reviewed and discussed with POA to reflect decisions on procedures including labs, vital signs and/or weights. • All MOLST forms will be reviewed for resident's choices. • Education with all Unit Coordinators/Supervisors by DON on checking MOLST forms and PCC for residents with regard to choices on labs, vital signs and weights. III. In an effort to ensure deficient	12/24/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/2021

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F 578	Continued From page 1 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interviews conducted during the Standard survey completed on 10/25/21, the facility did not honor the resident's right to formulate an advance directive for two (Resident #18, 24) of two residents reviewed. Specifically, Resident #18 and Resident 24 had Medical Orders for Life Sustaining Treatment (MOLST, a set of medical orders for advance directive status) that included the instructions for no weights and no laboratory (labs) testing (blood work); weights and laboratory tests were obtained for resident #18 and Resident #24. The findings are: The facility policy and procedure (P&P) titled "Medical Order for Life Sustaining Treatment	F 578	practice does not recur, the following systemic changes will be put in place: • Audits will be done monthly to ensure MOLST form decisions are reflected in PCC for 6 months. • Audits will include comfort care MOLST forms and 5 random residents from each unit. • Ensure orders in PCC reflect decisions made for treatments (including vital signs, weights, labs). • Ensure decisions made regarding treatments are reflecting in the instruction section of PCC. • Ensure all admission and readmission hospital paperwork is being reviewed for MOLST changes with social work follow-up • On the spot education will be provided for all staff not following policy. • No changes needed with current policy on MOSLT forms IV. The facility compliance will be monitored utilizing the following quality assurance system: • An audit tool will be developed to ensure residents that MOLST forms are being reviewed on a monthly basis and the choice(s) made by residents are documented in PCC. • Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results. Responsible Party: DON	

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	335212	A. BUILDING _____ B. WING _____	10/25/2021

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

(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) COMPLETE DATE
F 578	Continued From page 2 (MOLST)" dated 1/17/13, included Medical Orders for life sustaining treatment program is based on the premise that individuals have the right to make their own health care decisions. MOLST is based upon communication between the resident or health care proxy or legal decision maker, and the health care professionals that ensures informed medical decision making. The MOLST form is a bright pink medical order form signed by a New York State licensed physician that communicates resident's wishes regarding life-sustaining treatments to health care providers. The MOLST form includes types of intervention that the resident may or may not want. 1. Resident #18 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), dementia, and gastro-esophageal reflux disease (GERD, acid from stomach enters the esophagus). The Minimum Data Set (MDS, a resident assessment tool) dated 7/23/21 documented Resident #18 had severe cognitive impairment, and had Advance Directives that included feeding restrictions, and other treatment restrictions. Additionally, the MDS documented Resident #18 received comfort care (medical care and treatment provided with the primary goal of reducing suffering) in the last 14 days. The MOLST dated 9/18/19 included "Other instructions" of no labs and no weights. Resident #18's "Weights and Vital Summary" included weights were obtained on 10/7/21, 8/3/21, 6/2/21, 5/10/21, 5/2/21, and 4/30/21. Additionally, laboratory testing was obtained on 5/26/21.	F 578		

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F 578	Continued From page 3 The comprehensive care plan (CCP) included Resident #18 had Advanced Directives, with the goal, revision dated 5/18/21, choice of directive(s) will be honored through next review, and the intervention of a MOLST. There was no documented evidence in the Electronic Medical Record (EMR) the responsible party was contacted regarding obtaining weights and labs. 2. Resident #24 was admitted to the facility with diagnoses including dementia, anxiety, and depression. The MDS dated 8/12/21 documented Resident #24 had severe cognitive impairment, and had Advance Directives that included feeding restrictions, and other treatment restrictions. Additionally, the MDS documented Resident #24 received comfort care in the last 14 days. The MOLST dated 7/13/21 included "Other instructions" of no labs and no weights. Resident #24's "Weight Summary" included weights were obtained 10/5/21 and 8/2/21. The CCP included Resident #24 was on Comfort Care, initiated 7/13/21, with an intervention to evaluate diagnostics as per MOLST. There was no documented evidence in the EMR the responsible party was contacted regarding obtaining weights. During an interview on 10/19/21 at 9:11AM, Licensed Practical Nurse (LPN) #3, MDS trainee, stated they request weights for residents when they are completing the MDS'. LPN #3 stated they do not check the MOLST prior to	F 578		

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F 578	Continued From page 4 requesting weights from unit staff, and if the MOLST indicates "no weights" residents should not be weighed as that would be going against the residents wishes and physician orders. During an interview on 10/19/21 at 9:37AM, LPN #1 stated they were aware Resident #18 and Resident #24 had physician orders for no weights. LPN #1 stated weights were obtained per the request of the MDS trainee. Additionally, LPN #1 stated the responsible parties for Resident #18 and Resident #24 nor the physician were consulted prior to obtaining weights. During an interview on 10/22/21 at 8:32 AM, the Medical Director stated MOLSTs are reviewed every 60 days, and if the MOLST documents no weights and no labs, the expectation would be to avoid obtaining weights and labs. Additionally, the Medical Director stated the responsible party would be included in discussions related to the limitations of care prior to obtaining weights or labs. 415.3(e)(1)(ii)	F 578		
F 689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689	I. The following corrective actions were accomplished for the resident found to have been affected by the deficient practice: • Resident # 27 was assessed, with no injuries noted. Education provided to LPN and CNA involved by DON. II. All residents that have the potential to be affected by the deficient practice. • The following corrective actions will be taken: Education will be provided to all LPNs and CNAs on when to use gait belts by Unit Coordinators/Supervisors.	12/24/2021

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F 689	Continued From page 5 Based on observation, interview, and record review conducted during a Complaint investigation (Complaint # NY00278907) during the Standard survey completed on 10/25/21, the facility did not ensure each resident receives adequate supervision and assistance devices to prevent accidents for one (Resident #27) of seven residents reviewed for accidents. Specifically, Resident (#27) with a history of a bruise of unknown origin, that the facility concluded occurred during a transfer, was observed to be transferred by staff without the use of a gait belt (assistive device used to help safely transfer a resident). The finding is: The facility policy and procedure (P&P) titled "Safe Patient Handling/Safe Transfers and Movement", revised date 7/2021 documented all lifting and transferring of residents shall be performed utilizing the approved lift transfer devices and methods to prevent resident and employee injury. "Attachment #2 - Safe Resident Handling Assessment Tool" of the P&P documented transfer status of limited assist of one or two staff members and extensive assist of one staff member requires the use of a gait belt. 1. Resident #27 was admitted to the facility with diagnoses including dementia, generalized muscle weakness, and hypertension. The Minimum Date Set (MDS, a resident assessment tool) dated 8/13/21 documented Resident #27 had severe cognitive impairment, required extensive assistance (staff provide weight bearing support) of two or more staff for bed mobility and transfers. The comprehensive care plan (CCP)	F 689	III. In an effort to ensure deficient practice does not recur, the following systemic changes will be put in place: • 5 Random audits per week by unit managers for 3 months to ensure gait belt use per policy, with on the spot education performed as indicated. • No changes needed with current policy on transfers. IV. The facility compliance will be monitored utilizing the following quality assurance system: • Audit results will be reported to the QA&A Committee monthly for three months. Frequency of on-going audits will be determined by the Committee based on audit results. Responsible Party: DON	

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F 689	Continued From page 6 documented Resident #27 required extensive assistance of one staff member for bed mobility and transfers (date initiated 3/10/21). The facility "Incident/Accident Form" dated 7/3/21 documented bruising of unknown origin in the right axillary (armpit) region. The facility "Investigation Summary" dated 7/3/21 and signed by the Director of Nursing (DON) documented Resident #27's transfer status was an extensive assist of one. Certified Nurse Assistants (CNAs) reported they do not use a gait belt, and transfers were performed by holding on to trunk of the body. The DON concluded that "it appears resident may have been bruised during transfer. Upon investigation bruising aligns with transfer with staff hand position during bed to chair/wheelchair and toilet transfer." During an observation on 10/22/21 at 7:57 AM, CNA #1 and Licensed Practical Nurse (LPN) #2 transferred Resident #27 from the bed to the wheelchair by each placing an arm under the resident's arm, grabbing the back of the resident's pants, pulling the resident to a standing position, and pivoting the resident into a wheelchair without the use of a gait belt. During an interview on 10/22/21 at 9:53 AM, the Director of Rehab stated gait belts were required for any resident that required weight bearing assistance with a transfer. During an interview on 10/22/21 at 10:34 AM, CNA #1 stated they were unsure if gait belts were required during the transfer of Resident #27. During an interview on 10/22/21 at 10:36 AM,	F 689		

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F 689	Continued From page 7 LPN #2 stated they were unsure if gait belts were required during the transfer of Resident #27. During an interview on 10/22/21 at 10:40 AM, the Director of Rehab stated staff should avoid reaching under residents' arms to assist with transfers as it could cause bruising and dislocation of the shoulder. During an interview on 10/22/21 at 10:45 AM, the DON stated that all transfers requiring weight bearing assistance from staff required the use of a gait belt. Additionally, the DON stated Resident #27 has a history of bruising to the right axillary region from staff not utilizing a gait belt during transfer. During an interview on 10/22/21 at 1:17 PM, the Administrator stated gait belts were required for any transfer that required weight bearing assistance. Additionally, the Administrator stated gait belt was not on the CCP or Kardex (guide used by CNAs to provide care) because it was the facility policy to utilize a gait belt for any limited or extensive assist transfer. 415.12(h)(2)	F 689		

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I310 SS=E	415.29 Physical Environment This LICENSURE is not met as evidenced by: Based on observation and interview during the Recertification survey completed on 10/25/21, an air handling unit was not maintained in good repair and was not operated in a manner which would minimize the spread of infection and provide for resident health and comfort. Specifically, the facility had turned off an air handling unit that supplied fresh air to the interior of the building and removed exhaust air from the interior of the building. This affected three (Canal View, Garden View, Orchard View) of five resident units. The finding is: Observations in the Villages Penthouse on 10/18/21 at 1:05 PM revealed the air handling unit was not running. Further observation revealed two access panel doors had been removed from the unit and were stored resting on the side of the unit. Continued observation revealed five access panel doors were open instead of being closed and locked. During the observation the Maintenance Director stated the facility had turned the Village's air handling unit off after a contractor had inspected the unit and advised the facility to turn the unit off because no regular preventative maintenance had been done on the unit and more damage could be done to the unit if the facility kept it running. The Maintenance Director further stated the air handling unit brought fresh air into the building	I310	1. The Air Handler unit was turned on 10/20/2021. The access panel doors were in place and closed and locked. 2. An initial audit was conducted by the director of maintenance or designee to ensure the air handler was operating effectively on the Villages – Garden, Canal, and Orchard 3. The air handler unit will be scheduled for preventative maintenance and repair as indicated, per part and vendor availability. 4. The director of maintenance shall review and report findings from vendor on the operation of the air handler and convey to the administrator or designee. 5. The Director of Maintenance will provide quarterly reports on air handler inspection to the QAPI committee for the next 12 months. The QAPI Committee will review this plan, audit the effectiveness of the action, offer guidance and continued education. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	12/24/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	11/18/2021

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I310	Continued From page 1 and exhausted air from inside the building to the outside for Canal View, Garden View and Orchard View resident units. During an interview on 10/22/21 at 11:05 AM the Administrator and the Maintenance Director stated: -An outside contractor inspected the air handling unit in the Penthouse on 9/23/21. -This contractor advised the facility on 9/23/21 to turn the unit off because no regular preventative maintenance had been done on the unit, and more damage could be done to the unit if the facility kept running the unit. - The contractor advised that opening windows on the units would provide enough ventilation to the Canal View, Garden View and Orchard View resident units. -The air handler provided fresh air for the Villages building (Canal View, Garden View, and Orchard View units). -Since the unit had been turned off, the facility opened windows on Canal View, Garden View and Orchard View units, opened the corridor doors that separated the units from the existing building, and put fans on the units to provide ventilation. -The air handling unit in the Penthouse had been turned off from 9/23/21 until 10/20/21. -The facility had been in contact with the outside contractors and a consultant from 9/17/21 through 10/19/21. - The Administrator and the Maintenance Director stated they turned the air handling unit back on, on 10/20/21 after talking to the Surveyor about the unit being turned off. -The Administrator and the Maintenance Director stated they had no safety concerns or concerns of a fire if the air handler was left running. The only concern they had was mechanical.	I310		

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I310	Continued From page 2 Review of a work order from the contractor that inspected the air handling unit in the Penthouse on 9/23/21 revealed: Unit has major mechanical issues from maintenance neglect. Found main supply air fan had broken structural steel brackets and braces. Main fan shaft and bearing defective. Blower wheel and vortex cones damaged. Mounting discharge air bracket and flex connector damaged. 25 horsepower motor and fan shaft drive sheaves very worn. Air filters in all compartments severely plugged, missing, or falling apart. Heat wheel air passages very fouled up from inadequate filtration, heat wheel drive belt broken. Installed grease fitting on unit exhaust fan, greased bearings and checked drive belts that is in fair condition. Humidifier off on fault code non-operational. Unit needs extensive repairs to get unit operational. 415.29 (h)(1)	I310		

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	335212	A. BUILDING 01 - 1960 BLDG. B. WING _____	10/25/2021

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K 100 SS=E	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 10/25/21, the facility did not maintain the building to minimize the possibility of a fire emergency requiring the evacuation of occupants. Specifically, excessive amounts of lint and dust in, on, and around the laundry room's clothes dryers and on the exterior of the building and ground outside of the laundry room. This affected the Laundry room and the Service corridor. The findings are: 1a. Observations on the exterior of the building outside of the Laundry room on 10/18/21 at 9:31 AM revealed the following: -Two, four-foot-long by two-foot-wide areas of the exterior wall of the building were covered with a layer of lint and dust that ranged from one quarter inch to two inches in thickness. -Three, six-foot-tall by four-foot-wide widows were covered with lint and dust that ranged from one quarter inch to one half inch in thickness. -An 18 foot-long by 10-foot-wide area of the ground below the three laundry dryer vents was covered with a layer of lint and dust that ranged from one-quarter of inch to two-inches in	K 100	1. Dust and Lint were removed from the interior area behind and on top of the dryer, the interior and windows behind the dryers. The dust and lint will be cleared from the exterior windows, wall, ground, and white fencing outside the building. 2. The facility interdisciplinary team consisting of the Director of Maintenance, Director of Environmental Services, and Administrator created a schedule by which the internal dryer area will be inspected and cleaned in the presence of lint build up weekly, and the exterior area will be inspected, ongoing, monthly. 3. The Director of Housekeeping re-inserviced housekeeping/laundry personnel on cleaning the dryer area. The Administrator re-inserviced the Director of Maintenance on cleaning of the exterior dryer area. 4. The Director of Housekeeping will utilize a weekly audit tool to indicate inspection of the dryer area for lint build up and report to QA completion. The Director of Maintenance will utilize a monthly audit tool to identify lint build up exteriorly. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	12/24/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/16/2021

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 100	Continued From page 1 thickness. - A plastic fence installed around the three dryer vents was covered with a layer of lint and dust that ranged from one-quarter of an inch to two inches in thickness. During the observation, the Maintenance Director stated the facility had no maintenance logs for cleaning the windows, the exterior walls of the building or the ground located near the laundry dryer vents. The Maintenance Director further stated none of the facility staff had cleaned the exterior areas of the building located around the laundry dryer vents. 1b. Observations in the Laundry room located on the Service corridor on 10/18/21 at 11:23 AM revealed the following: -A five-foot tall by eight-foot long by one-inch wide area between clothes dryer #2 and dryer #3 was full of lint and dust. Further observation revealed a five-foot tall by-eight foot long by one-inch wide area between dryer #1 and a wall in the Laundry room was full of lint and dust. -The tops of all three clothes dryers were covered with a layer of lint and dust that ranged from one-quarter inch to one-half inch in thickness. -An eight-foot long by three-inch wide area of the floor behind the three dryers was covered with a layer of lint and dust that ranged from one-quarter inch to one-half inch in thickness. - Three six-foot tall by four-foot wide widows and their screens were covered with lint and dust that ranged from one quarter inch to one half inch in thickness. During the observation the Maintenance Director stated the area behind the dryers was last cleaned in June of 2021 and the facility had no	K 100		

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K 100	Continued From page 2 maintenance logs for cleaning the areas behind, between, and around the dryers. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.1.1.3.1, 4.6.12.2	K 100		
K 111 SS=E	NFPA 101 Building Rehabilitation Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)	K 111	1. a. The twelve, 2"x2" penetrations between the metal cross arm supports that attach to the building's roof trusses, one 3'x1" penetration through the fire barrier wall, eighteen 3"x2" penetrations that separate the penthouse from the Canal View attic and are between the metal cross arm supports that attach to the building's roof trusses and are installed through the fire barrier wall located above the penthouse stairway, and two 10'x2" penetrations in the gypsum board fire rated wall on the left and right sides of the fire rated door that separate the Penthouse stairway from Canal View were sealed with a fire rated material. b. The one 3'x1 ½" penetration between the fire barrier wall and the top of the door frame of the fire barrier door that separates the attic from the penthouse, 2" wide penetrations around two 3'x18" wide ventilation ducts installed through the fire barrier wall that separate the Orchard View attic from the penthouse, five 1'x1 ½" wide penetrations through the fire barrier wall on the left and right sides of the door frame of the fire barrier door that separates the Orchard View attic from the penthouse, one 8'x ¼" wide penetration in the fire barrier wall that separates the Orchard View attic from the penthouse, one 2'x2' wide penetration above the flexible metal electrical lines that are installed through the fire barrier wall that separate the	12/24/2021

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	335212	A. BUILDING 01 - 1960 BLDG. B. WING _____	10/25/2021

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K 111	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed 10/25/21, fire barriers were not properly maintained. Specifically, fire barrier walls were not complete from floor to ceiling/roof deck, were not designed to have the appropriate fire resistance rating and were not designed to be resistant to smoke due to a penetrations through the fire barriers walls. This affected two (the fire barrier between the Penthouse and the Canal View, Garden View, and Orchard View attics; and the fire barrier between the Lobby and the Administrative wing,) of four fire barriers. The findings are: The Villages building had attics above Canal View, Garden View, and Orchard View. Access to the attics was through the Penthouse. The Penthouse is protected by an automatic sprinkler system. The attics are not protected by an automatic sprinkler system. The attics roofs have an interior wooden deck with steel panel covering the exterior. 1a. Observations of the fire barrier wall that separated the Canal View attic from the penthouse, on 10/18/21 at 1:00 PM revealed: -12, two-inch-long, by two-inch-wide penetrations were filled with mineral wool that was not sealed with a fire rated material. Further observation revealed these penetrations were between the metal cross arm supports that were attached to the building's roof trusses. -One, three-foot-long by one-inch-wide penetration through the fire barrier wall. -18, three inch long by two inch wide penetrations through the fire barrier wall that	K 111	Orchard View attic from the penthouse, one ½" circular penetration through the fire barrier wall that separates the Orchard View attic from the penthouse were sealed with a fire rated material. c. The one 3'x ½" wide penetration between the fire barrier wall and the top of the frame of the fire barrier door that separate the Garden View attic from the penthouse, one 5'x ½" penetration in the fire barrier wall on the left and right sides of the frame of the fire barrier door that separate the Garden View attic from penthouse. One 12'x ¼" wide penetration in the fire barrier wall that separate the Garden View attic from the penthouse. d. The one 10"x10" wide penetration through the fire barrier that separates the Lobby from the Administrative wing near the fireplace was sealed with a fire rated material. 2. Initial audit by Director of Maintenance of fire barriers to identify areas of penetration. 3. Life Safety Consultant in-serviced Administrator and Director of Maintenance on the regulation to ensure fire barriers are sealed with at least a 2 hour fire resistance rating. 4. The Director of Maintenance or designee shall audit, ongoing, quarterly for fire barrier penetrations to ensure they are properly sealed. 5. a. Quality Assurance Audits will be created	

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K 111	Continued From page 4 separated the Penthouse from the Canal View attic were filled with mineral wool that was not sealed with a fire rated material. Further observation revealed these penetrations were between the metal cross arm supports that were attached to the building's roof trusses and installed through the fire barrier wall. Further observation revealed these penetrations were located above the Penthouse stairway. -Ten foot long by two inch wide penetrations in the gypsum board fire rated wall on the left and right sides the fire rated door that separated the Penthouse stairway from Canal View. 1b. Observations of the fire barrier wall that separated the Orchard View attic from the penthouse, on 10/18/21 at 1:16 PM revealed: -One, three-foot-long by one-half-inch-wide penetration between the fire barrier wall and the top of the door frame of the fire barrier door that separated the attic from the Penthouse. -Five, one foot-long by one-half-inch-wide penetrations through the fire barrier wall, on the left and right sides of the door frame of the fire barrier door that separated the attic from the Penthouse. -Two inch wide penetration around two, three foot long by 18 inch wide ventilation ducts that were installed through the fire barrier wall that separated the attic from the Penthouse. -One, eight foot long by one quarter inch wide penetration in the fire barrier wall that separated the attic from the Penthouse. -One, two inch long by two inch wide penetration above two flexible metal electrical lines that were installed through the fire barrier wall that separated the attic from the Penthouse. -One, half inch circular penetration through the fire barrier wall that separated the attic from the Penthouse.	K 111	for the DPOC for the Director of Maintenance or designee to audit, ongoing, quarterly for fire barrier penetrations to ensure they are properly sealed. b. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Director of Maintenance shall be responsible for implementation of this plan of correction and the Administrator will monitor for compliance.	

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K 111	Continued From page 5 1c) Observations of the fire barrier wall that separated the Garden View attic from the penthouse, on 10/18/21 at 1:22 PM revealed: -One, three foot long by one half inch wide penetration between the fire barrier wall and the top of the frame of the fire barrier door that separated the attic from the Penthouse. -Five foot long by one half inch wide penetrations in the fire barrier wall on the left and right sides of the frame of the fire barrier door that separated the attic from the Penthouse. -One, 12 foot long by one quarter inch wide penetration in the fire barrier wall that separated the attic from the Penthouse. During the observation the Maintenance Director stated the facility conducted monthly inspections of smoke and fire barriers and the Penthouse and attics were not checked as part of the monthly inspections. 2a. Observations above the ceiling tiles in the Lobby on 10/19/21 at 10:40 AM revealed a ten inch long by ten inch wide penetration through the fire barrier wall was filled with mineral wool that was not sealed with a fire rated material. Further observation revealed the penetration was through the fire barrier wall that separated the Lobby from the Administrative wing. Continued observation revealed the penetration was near the electric fireplace. Review of monthly Smoke/ Fire Barrier Walls Audit forms revealed the last audit was completed on 10/16/21. Further review of the forms revealed the Penthouse and attics were not listed on the forms. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.1.1.4.1, 8.3, 8.3.1.1, 8.3.1.2	K 111		

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K 225	Continued From page 6	K 225		
K 225 SS=D	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 10/25/21, a stairway used as an entrance/exit was not properly maintained. Specifically, a stairway door did not self-close and latch into its door frame. This affected the Basement and the Education room. The finding is: Observations in the Education room on 10/18/21 at 11:03 AM revealed the following: -Access to the Basement stairway was through a single door located in this room. -The Basement stairway door would not self-close and latch into its doorframe, leaving a one inch gap between the door and its frame. -The door was held open by two electrical wires that were hung up in the doors self-closing device. -The electrical wires were installed along the wall of the Education room above the Basement stairway door. -The Basement stairway door separated the Basement from the Education room. -The Basement stairway door forms part of the compartment that separated the building's transfer switch equipment (for the building's emergency generator) from the Education room.	K 225	1. The door leading from the Education room to the basement was repaired to be self-closing and latch into the frame. The electrical wires were cleared from impeding the door opening and closing. 2. An initial audit was completed by the director of maintenance or designee to confirm stairway doors were self-closing and latch into their frame. 3. The Director of Maintenance was re-inserviced by the administrator on the regulation to ensure stairway doors are self-closing and latch into their frame. 4. The Director of Maintenance or designee shall audit, ongoing, monthly for stairway doors to be self-closing and latch into their frame. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	12/24/2021

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K 225	Continued From page 7 During the observation the Maintenance Director stated the two electrical wires were data lines for the computer in the Education room. The Maintenance Director further stated the facility had logs documenting the monthly checks of the building's doors. A review of the monthly Self-Closing Doors logs revealed the building's doors were last inspected in October of 2021. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 7.1, 7.1.3.2.1(1), 19.2.2.3, 7.2, 7.2.2, 7.2.1.1	K 225		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321	1. Hazardous area doors were inspected to be un-propped and self-close and latch to their frame. Specifically: Laundry door - hinges were repaired and it will be affixed with a self latching device. Doctor's office door – deadbolt repaired to retract into frame. Orchard Soiled Utility room – hinges tightened and alignment corrected to latch into the frame. Kitchen/Medical Supply – signage laminated and placed on doors indicating not to be propped open. Activity Storage – self closure device will be added. 2. An initial audit was completed by the director of maintenance or designee to confirm hazardous area doors self-close and latch into their frame and are not obstructed from closing. 3. Directed in-service per directed plan of correction for Administrator, Director of Maintenance, Director of Environmental Services and DON ensuring hazardous doors are un-propped and self-close and latch to their frame. 4. The Director of Maintenance or designee shall audit, ongoing, monthly for	12/24/2021

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K 321	Continued From page 8 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 10/25/21, doors protecting hazardous area were not maintained. Specifically, doors did not self-close and latch, and doors were held open and obstructed form closing. This affected the Service corridor, One (Orchard View) of five resident units, A Unit, and the Administrative Wing, the Main Kitchen, the Service corridor, and the Doctor's office. The findings are: 1a. Observations in the Service corridor on 10/18/21 at 11:37 AM revealed the Laundry soiled linen/ washing machine room corridor doors did not self-close and latch into their frame resulting in a four-inch gap between the doors. Further observation revealed the doors' hinges were not secured to the doors. During the observation the Maintenance Director stated the door hinges were loose, probably from laundry carts hitting the doors. 1b. Observation in the Main Kitchen on 10/18/21 at 11:59 AM revealed the Kitchen's corridor door, located closest to the paper goods storage room, was obstructed from closing by a three-tiered dietary cart. During the observation the Maintenance Director stated staff knew not to obstruct the doors form closing. 1c. Observation in the Doctor's office on 10/18/21 at 12:18 PM revealed the door to the	K 321	hazardous area doors to be self-closing and latch into their frame and are not obstructed from closing. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Director of Maintenance shall be responsible for implementation of this plan of correction and the Administrator will monitor for compliance.	

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K 321	Continued From page 9 storage room within this office did not self-close and latch into its frame. Further observation revealed the door's dead bolt lock was obstructing the door from closing. Continued observation revealed the storage room was greater than 50 square feet and contained six cardboard cases of testing vials, three boxes of testing kits, one case of syringes, one four-tiered shelving unit full packages and bags of vials, boxes of gloves, sharps containers, one 32-gallon trash receptacle, four file cabinets, one dresser, one lamp, and one hydrocollator. Observations also revealed the Doctor's office corridor door did not self-close and latch into its frame and the door was not was not equipped with a self-closing device. During the observation the Maintenance Director stated the bolt for the door's dead bolt lock was obstructing the door from closing and he was not sure when the room had become a storage room. 1d. Observation on the Orchard View Unit on 10/18/21 at 2:00 PM revealed the Soiled Utility room corridor door located near Resident Room #19 did not self-close and latch into its frame. 1e. Observation on the A Unit, located off the Administrative Wing, on 10/18/21 at 2:32 PM revealed the Activity storage room door was not equipped with a self-closing device. Further observation revealed the room was greater than 50 square feet and contained one six foot tall by eight foot long by one-foot-wide clothing rack full of shirts, shoes, and sneakers, two, five foot tall by four foot long by two-foot-wide racks and two, six foot tall by three foot long by one-foot-wide racks full of stuffed animals, quilts, paint and art supplies, board games, holiday decorations, and toys.	K 321		

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K 321	Continued From page 10 1f. Observation in the Service corridor on 10/22/21 at 7:31 AM revealed two cases of vinyl disposable gloves were on the floor, obstructing the Medical Supply Storage room's corridor door from closing. Further observation revealed the room was greater than 50 square feet and contained six, seven foot tall, by four foot long by two-foot-wide metal shelving units full of medical supplies including but not limited to: boxes and packages of conforming sterile gauze, cotton tipped wooden applicators, irrigation trays with piston syringes, bordered foam, gauze bandages, gauze sponges, and vinyl gloves. Review of the facility's monthly Self-Closing Doors logs revealed the building's doors were last inspected in October of 2021. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.3.2.1 2012 NFPA 101: 19.2.2.2.7	K 321		
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions	K 324	1. The manual pull station for the kitchen hood extinguishment system was inspected. 2. An audit was performed to confirm the presence of all kitchen hood extinguishment systems. 3. The Director of Maintenance was re-inserviced by the administrator on the regulation to inspect the kitchen hood extinguishment system monthly. 4. The Director of Maintenance or designee shall audit, ongoing, monthly for inspection of the kitchen hood extinguishment system.	12/24/2021

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K 324	Continued From page 11 under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation, interview, and record review during the Life Safety Code survey completed on 10/25/21, the manual pull station for the kitchen's hood extinguishment system was not properly inspected. Specifically, the manual pull station for the kitchen hood extinguishment system was not inspected monthly. This affected the Main Kitchen. The finding is: Observation in the Main Kitchen on 10/18/21 at 11:59 AM revealed no monthly inspections were recorded on the inspection tag that was attached to the manual pull station for the kitchen hood extinguishment system. Further observation of the tag revealed the manual pull station had been last inspected by an outside contractor in July 2021. During this observation, the Maintenance Director stated they were not aware the pull station had to be inspected monthly, and facility had no other records for the monthly inspections of the kitchen hood manual pull station. Review of a Systems Inspection and Test Report revealed the kitchen hood extinguishment system had been last inspected on 7/7/2021. 10 NYCRR 415.29(a)(2), 711.2(a)(1)	K 324	5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 324	Continued From page 12 2012 NFPA 101: 19.3.2.5.4, 9.2.3 2009 NFPA 17A: 7.2, 7.2.5	K 324		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 10/25/21, automatic sprinkler systems were not properly maintained. Specifically, a main sprinkler valve was leaking, and sprinkler heads were covered with dust and debris. This affected the building's sprinkler system, the Main Kitchen, the loading dock, and the Laundry room. The findings are: 1a. Observations of the facility's sprinkler system, in the Basement on 10/18/21 at 11:05	K 353	1. The leak from the 6 inch valve on the sprinkler system in the basement was repaired by an outside vendor on 11/05/2021. The pendent style sprinkler heads in the laundry room, Main Kitchen, and area of the loading dock between the Main Kitchen and dietary dry goods storage cage were cleared of debris. 2. An audit was performed to confirm no additional leaks existed in the sprinkler system. An audit was performed to confirm sprinkler heads are clear of debris. 3. The Sprinkler system is inspected quarterly by an outside vendor. 4. The Director of Maintenance or designee shall audit for 3 months the sprinkler system in the basement to ensure is it sealed/not leaking, and the sprinkler heads in the Main Kitchen, Loading Dock and Laundry room to ensure they are clear of debris. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	12/24/2021

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K 353	Continued From page 13 AM revealed water was leaking out of the top of a six inch valve. Further observations revealed wet, tan colored sediment on the valve and on the sprinkler piping located below the leaking valve. Continued observation revealed water was steadily leaking out of this valve, resulting in a 10 foot by five foot area of the Basement floor that was covered by a layer of water that was running into a floor drain. During the observation the Maintenance Director stated he was not aware the valve was leaking. The Sprinkler Contractor had recently been in the building and inspected and tested the sprinkler system. The Maintenance Director further stated that it appeared the sediment was in the water that was coming out of the valve and that there may be sediment inside the sprinkler pipes. The Maintenance Director also stated the facility had a contractor that inspected and tested the building's sprinkler system and the facility had no logs for the facility's inspections of the sprinkler valves. 2a. Observation in the Laundry room on 10/18/21 at 11:23 AM revealed three of seven pendent style sprinkler heads were covered with white colored lint and dust. 2b. Observation in the Main Kitchen on 10/18/21 at 12:05 PM revealed four of four pendent style sprinkler heads in the Kitchen were covered with black colored dust and debris. The Maintenance Director stated the facility had a contractor that inspected and tested the building's sprinkler system and the facility had no logs for the facility's inspections of the sprinkler heads. 2c. Observation in the loading dock on 10/18/21 at 12:08 PM revealed one pendent and one	K 353		

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K 353	Continued From page 14 upright sprinkler head were covered with dust, debris, and small bugs. Further observation revealed this area of the loading dock was located inside the building between the Main Kitchen and the dietary dry goods storage cage. Review of Wet Fire Sprinkler System Reports dated 8/19/21 and 6/24/21 revealed the reports had no documentation of any issues with the building's sprinkler valves or dirty sprinkler heads. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 9.7, 9.7.5 2011 NFPA 25: 4.1, 4.1.1, 5.1, 5.1.1.2, Table 5.1.1.2, 13.1, 13.1.1.1, 13.1.1.2, 13.3.2.1, 13.3.2.1.1, 13.3.2.2, 5.2.1.1.2	K 353		
K 355 SS=E	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 10/25/21, portable fire extinguishers were not properly maintained. Specifically, portable fire extinguishers were obstructed and fire extinguishers were not subjected to one year maintenance. This affected two (Autumn View North, Canal View) of five resident units and the Education room. The findings are: 1a. Observations on Autumn View North on	K 355	1. The extinguishers located on Autumn View North and Canal View were cleared from obstruction. The list for fire extinguishers was updated to include the education room. The extinguisher in the education room will be replaced. 2. An initial audit was completed by the director of maintenance or designee to identify all extinguishers remained free of obstruction, and are current in their yearly maintenance. 3. The Director of Maintenance was re-inserviced on the regulation to ensure all fire extinguishers remain free of obstruction and are maintained yearly. 4. The Director of Maintenance shall audit, ongoing, monthly to ensure fire extinguishers are unobstructed, and their yearly maintenance schedule is current. 5. Audits shall be reviewed at the	12/24/2021

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K 355	Continued From page 15 10/18/21 at 10:14 AM revealed a clean linen cart was stored in front of and obstructing the portable fire extinguisher near Resident Room #220. During an interview on 10/18/21 at 10:34 AM the Maintenance Director stated the staff had to be reminded not to block fire extinguishers. 1b. Observations on Canal View on 10/20/21 at 1:11 PM revealed a cart was stored in front of and obstructing the portable fire extinguisher located near Resident room #41. 2a. Review of the inspection tag that was attached to fire extinguisher #14 in the in the Education room on 10/18/21 at 10:52 AM revealed the extinguisher had been put in service in April of 2020. Monthly inspections were recorded on the tag from April 2020 through December of 2020, and January 2021 through September of 2021. Further review of the tag revealed yearly maintenance, due April 2021, had not been performed on the extinguisher. During the observation the Maintenance Director stated he had created a Fire Extinguisher Audit list and had numbered the building's fire extinguishers. The Maintenance Director further stated the contractor that inspected and tested the building's fire extinguishers must have missed the extinguisher in the Education room. Review of the Fire Extinguisher Inspection List dated 4/23/2021 from the contractor that inspected and tested the building's fire extinguishers revealed the fire extinguisher located in the Education room was not documented on this inspection list. 10 NYCRR 415.29(a)(2), 711.2(a)(1)	K 355	QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 355	Continued From page 16 2012 NFPA 101: 19.3.5.12, 9.7.4.1 2010 NFPA 10: 6.1.3.3, 6.1.3.3.1, 7.3.1.1, 7.3.1.1.1, 7.3.1.1.2, Table 7.3.1.1.2.	K 355		
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 10/25/21, smoke barrier walls were not properly maintained. Specifically, smoke barrier walls were not complete from floor to roof deck and were not designed to have at least a 30-minute fire resistance rating. This affected one (Autumn View South) of five resident units and the Main Lobby. The findings are: 1a. Observations above the ceiling tiles on Autumn View South unit on 10/19/21 at 10:11 AM revealed unsealed mineral wool filled a four-inch-long by three-inch-wide penetration and a three-inch-long by two-inch-wide penetration thorough the smoke barrier wall, above the	K 372	1. The 4"x3" and 3"x2" wide penetration above the ceiling tiles on Autumn View South that separate Autumn View South from the Lobby were sealed. The two 4"x2", one 4"x1", one 4"x3", and one 12"x10" wide penetrations between the Main Lobby and Autumn View South were sealed. 2. An initial audit was completed by the director of maintenance or designee to ensure smoke barrier walls were properly sealed to have at least a 30 minute fire resistance rating. 3. Life Safety Consultant in-serviced Administrator and Director of Maintenance on the regulation to ensure smoke barrier walls are properly sealed. 4. a. Quality Assurance Audits will be created for the DPOC for the Director of Maintenance or designee to audit, ongoing, quarterly for smoke barrier penetrations to ensure they are properly sealed. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Director of Maintenance shall be responsible for implementation of this plan of correction and the Administrator will monitor for compliance.	12/24/2021

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K 372	Continued From page 17 smoke barrier doors, that separated Autumn View South unit from the Main Lobby. During the observation, the Maintenance Director stated the facility conducted monthly inspections of the smoke and fire barrier walls and the facility had documentation for these inspections. 1b. Observations above the ceiling tiles, in the Main Lobby, above the smoke barrier doors that separated the Main Lobby from Autumn View South unit, on 10/19/21 at 10:26 AM revealed the following: -Two, four-inch-long by two-inch-wide penetrations and one, four-inch-long by one-inch-wide penetration through the smoke barrier wall that were filled with a clear silicon caulk. -One, four-inch-long by three-inch-wide penetration above a three-inch diameter insulated pipe that was installed through the smoke barrier wall, was filled with yellow colored expandable foam. -One, 12-inch-long by 10-inch-wide penetration to the left side of a four-inch diameter sprinkler pipe that was installed through the smoke barrier wall was filled with pink insulation foam board. Review of the facility's monthly Smoke/ Fire Barrier Walls Audits revealed the last audit was completed on 10/16/21. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101:19.3.7, 19.3.7.3, 8.5, 8.5.2, 8.5.2.1, 8.5.2.2	K 372		
K 521 SS=E	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521	1. #38 FSD -03 and #37 FSD-02 repair will be scheduled with local vendor, EMCOR Services, per part availability. For #23 FSD -32, #22 FSD-33, #21 FD-2, and #1 FD-10 new damper installation will been scheduled with a local vendor, EMCOR Services, per part availability. 2. An initial audit of facility damper	12/24/2021

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K 521	Continued From page 18 This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 10/25/21, fire/smoke dampers were not maintained. Specifically, fire/ smoke dampers that failed inspection were not repaired or replaced. This affected two (Autumn View North, Autumn View South) of five resident units and the Penthouse. The findings are: Observations in the Villages Penthouse on 10/18/21 at 1:23 PM revealed fire/smoke dampers were installed in the ventilation ducts that went through the fire barrier walls. Observations above the ceiling tiles on Autumn View North in Resident Room #230 on 10/19/21 at 9:53 AM revealed a smoke damper was installed in the ventilation duct that was installed through the smoke barrier wall. Observations above the ceiling tiles on Autumn View South in Resident Room #213 on 10/19/21 at 9:57 AM revealed a smoke damper was installed in the ventilation duct that was installed through the smoke barrier wall. Review of an independent contractor's Damper Inspection Report dated 6/23/21 revealed four Fire Smoke Dampers (FSD) and two Fire Dampers (FD) were listed as "Fail" on this report. Further review of the Damper Inspection Report revealed the following notes were written under the heading "Damper Deficiency Report": - #38 FSD-03, inside Resident Room #230 Fail, new damper required	K 521	Inspection reports was conducted to ensure no additional dampers were in need of repair, had failed, and no additional dampers are needed. 3. An audit/inspection and testing of all fire dampers has been scheduled through a local vendor to ensure all fire dampers are in proper working order and to make any necessary repairs. 4. The director of maintenance was re-educated to ensure all fire damper inspection reports are reviewed for recommendations and follow up. 5. Fire damper inspection reports will be submitted directly to the administrator. 6. The Director of Maintenance will provide reports on all fire damper inspections to the QAPI committee as applicable. The QAPI Committee will review this plan, audit the effectiveness of the action, offer guidance and continued education. The Director of Maintenance Services is responsible for this plan.	

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K 521	Continued From page 19 - #37 FSD-02, inside Resident Room #213 Fail, new damper required - #23 FSD-32, Penthouse, no damper present, new damper required - #22 FSD-33, Penthouse, no damper present, new damper required - #21 FD-29, No damper present, new damper required. - #1 FD-10, Requires duct access door, no damper present Review of a letter dated 6/25/21 from this contractor stated: "Please note, if you find your facility out of compliance, take time to review your deficiency list to determine if interim life safety measures need to be put into place." Further record review revealed this contractor provided the facility with a quote to repair/replace dampers on 7/13/2021. During an interview on 10/22/21 at 11:21 AM the Administrator and the Maintenance Director stated they had been in contact with the contractor, a consultant, and a second contractor from 6/28/21 through 10/18/21. The Maintenance Director stated the facility's consultant was looking for additional quotes for the damper repairs as of 9/27/21. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.5.2.1, 9.2, 9.2.1 2012 NFPA 90A: 5.4.8.1, 5.4.8.2 2010 NFPA 80: 19.2, 19.4, 19.4.3, 19.4.11 2010 NFPA 105: 6.6, 6.6.3, 6.3.2.4	K 521		
K 911 SS=E	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but	K 911	1. The electrical wires above the ceiling tile on Autumn View South in Resident Room #213 were installed inside of an electrical junction box. The cover plate from the building's fire alarm system above the ceiling tiles in the Main Lobby was	12/24/2021

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K 911	Continued From page 20 are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 10/25/21, electrical wiring was not properly maintained. Specifically, electrical wiring was not installed inside of electrical junction boxes and an electrical junction box was missing its cover plate. This affected one (Autumn View South) of five resident units and the Main Lobby. The findings are: 1a. Observations above the ceiling tiles on the Autumn View South Unit in Resident Room #213 on 10/19/21 at 9:57 AM revealed the flexible metal sheath was removed from two sets of electrical wires. The electrical wires were taped together with electrical tape and the wires were not installed inside of an electrical junction box. Further observations revealed the electrical lines were supplying power to two televisions. During the observation the Maintenance Director stated remodeling had occurred at the facility, prior to the Maintenance Director working at this facility. 1b. Observations above the ceiling tiles in the Main Lobby on 10/19/21 at 10:32 AM revealed the flexible metal sheath had been removed from two sets of electrical wires. The electrical wires were taped together with electrical tape, wire nutted together, and were not installed inside of an electrical junction box. 1c. Observations above the ceiling tiles in the Main Lobby on 10/19/21 at 10:41 AM revealed	K 911	replaced. The electrical wires above the ceiling tiles in the Main Lobby will be installed inside of electrical junction boxes. 2. An initial audit was conducted by the director of maintenance or designee to ensure electrical wires above the ceiling tiles on Autumn South and the Main Lobby were properly inside junction boxes, and have properly installed cover plates. An initial audit was performed to include ceiling tiles above Autumn North for the presence of junction boxes and cover plates. 3. The director of maintenance was re in serviced by the administrator on the regulation to ensure electrical wiring is property inside junction boxes and electrical junction boxes had properly installed cover plates. 4. The director of maintenance shall audit monthly for 3 months to identify electrical junction boxes are properly placed and maintained. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action	

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K 911	Continued From page 21 an electrical junction box for the building's fire alarm system was missing its cover plate. Further observations revealed two electrical lines were wire nutted together and the lines were not installed inside of an electrical junction box. During the observations, the Maintenance Director stated the junction box was for the building's fire alarm system and he was not aware the junction box was missing its cover. 1d. Observations above the ceiling tiles in the Main Lobby on 10/19/21 at 10:54 AM revealed electrical wires were out of their flexible metal sheaths and were not installed within an electrical junction box. During an interview on 10/22/21 at 9:21 AM the Maintenance Director stated the facility was not conducting audits of the electrical wiring located above the ceiling tile assemblies. 2012 NFPA 99: 6.1, 6.1.1, 1.3, 1.3.2.1, 6.3.2, 6.3.2.1, 2011 NFPA 70: 110.3(A)(1)(8), 110.12, 314.25, 314.72(C), 406.6	K 911		
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918	1. The two facility generators were exercised under load for 30 minutes. 2. An initial audit was conducted by the director of maintenance or designee to ensure generators operate effectively under load. 3. The director of maintenance was re in serviced by the administrator on the regulation to test each generator under load for 30 minutes monthly. 4. The director of maintenance shall audit, ongoing, monthly that each generator is exercised under load for 30 minutes. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance.	12/24/2021

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K 918	Continued From page 22 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 10/25/21, emergency generators were not properly maintained. Specifically, the facility's two emergency generators (generator #1 and generator #2) were not exercised under load for at least 30 minutes monthly. The finding is: Observation on 10/18/21 at 11:54 AM revealed the facility's two emergency generators were located on the exterior of the building near the corridor that connected the existing building with the 2006 addition. During the observation the Maintenance Director stated they turned the two generators on once a month, let them run for	K 918	The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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

(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) COMPLETE DATE
K 918	Continued From page 23 one hour, and did not use the transfer switches. The Maintenance Director further stated that sometimes the generator comes on automatically and the Maintenance Director believed the contractor that inspects and tests the generators may have been running the generators remotely. During an interview on 10/19/21 at 2:42 PM the Maintenance Director stated he was never trained on how to conduct a load test using the transfer switches. During an interview on 10/21/21 at 9:50 AM the Administrator stated the contractor that inspected and tested the facility's emergency generators was contacted, and the contractor explained how to conduct a load test using the transfer switches. The Administrator further stated he and the Maintenance Director would conduct a load test on the facility's emergency generators. Review of the Emergency Generator Monthly Test Log revealed the facility's two emergency generators, generator #1 and generator #2 were run monthly for at least 30 minutes from 4/29/21 through 9/22/21. Further review of the log revealed no other documentation that the generators had been run under load for at least 30 minutes every month. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 99: 6.5.4, 6.4.1, 6.4.4.1.1.4(A)(B)(C) 2010 NFPA 110: 8.4, 8.4.1	K 918		
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920	1. The extension cord in the Laundry room was removed and the portable air conditioner removed. The extension cord in the Boiler room was removed and the heat tape will be removed from the sprinkler piping. The extension cord in the	12/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING 01 - 1960 BLDG. B. WING	10/25/2021

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

(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) COMPLETE DATE
K 920	Continued From page 24 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 10/25/21, extension cords and power strips were not properly maintained. Specifically, in-use extension cords and power strips were plugged together and being used to supply power to various equipment, and in-use extension cords were plugged together and being used to supply power to various equipment. This affected the Laundry, the Boiler room and the Doctor's office. The findings are: 1a) Observations in the Laundry clean linen room on 10/18/21 at 11:23 AM revealed an extension cord that was plugged into a power strip that supplied power to a window fan.	K 920	Doctor's office was removed and the fan was plugged into the wall outlet. 2. An initial audit was conducted by the director of maintenance or designee to ensure extension cords were not in use. 3. The director of maintenance was re in serviced by the administrator on the regulation to ensure extension cords are not being used. 4. The director of maintenance shall audit, monthly for 3 months to ensure extension cords are not being used. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING 01 - 1960 BLDG. B. WING	10/25/2021

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

(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) COMPLETE DATE
K 920	Continued From page 25 Further observation revealed a power strip plugged into an extension cord was supplying power to a portable air conditioning unit. During the observations, the Maintenance Director stated he was not aware that extension cords were used in the Laundry room. 1b) Observation in the Boiler room on 10/18/21 at 11:44 AM revealed two extension cords supplied power to heat tape, that was wrapped around sprinkler piping. During the observation the Maintenance Director stated he was not aware the extension cords were used in the Boiler room. 1c. Observation in the Doctor's office on 10/18/21 at 12:18 PM revealed an extension cord was used to supply power to a fan that was on and running. During the observation the Maintenance Director stated he was not aware the extension cords were being used in the Doctor's office. During an interview on 10/22/21 at 9:21 AM the Maintenance Director stated the facility did not conduct audits for extension cords and power strips. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 99: 10.2.4, 10.2.4.2, 10.2.4.2.1, 10.2.4.2.3, 10.2.3, 10.2.3.3.3, 10.2.3.6 2011 NFPA 70: 110.3(A)(1)(8), 400.8(1), 590.3(B)	K 920		

EXHIBIT 42

Project:

The Villages of Orleans Health and Rehab Center

Quality In Cite®

[HUD On-Site Risk Management Assessment : MARCH 15, 2019]

3500 Lenox Rad NE, Suite 510 ◆ Atlanta, GA 30326 678. 578. 8375 ◆ 678.680.4956 fax

Quality In Cite™

Ms. Lisa Braack
HHC Finance
5515 Security Lane
North Bethesda, Maryland 20852

Dear Ms. Braack,

Thank you for the opportunity to provide a risk management assessment for The Villages of Orleans Health and Rehab Center located at 14012 NY-31 #1, Albion, NY 14411. The primary objective of this service was to identify the potential clinical, regulatory and, operational risks and exposures for this operator as defined in our *Scope of Work* and to provide an executive narrative summarizing the findings of the review. The key components of our analysis included off-site data review as well as an on-site interview with facility leadership to better understand the operational and clinical management model of the facility, to define any mitigation strategies for key areas of clinical/regulatory risk, and to identify the systems and leadership in place for sustainable quality of care outcomes. In addition, a facility tour was conducted to observe various aspects of care provided and the life safety of the environment.

Our reporting and analysis is limited to the accuracy and availability of information from both publicly reported and operator provided information. The analysis, opinions, and conclusions contained herein are specific to this engagement and a result of the aforementioned sources and in no way is warranted nor guaranteed for accuracy. All information provided within this report is proprietary and for use only by HHC Finance, HUD and Bernard Fuchs/The Villages of Orleans. Any other uses for this report must be discussed and approved, in writing, by Quality In-Cite, LLC. A list of exhibits with sources can be found at the end of this report.

Regulatory Performance History

To evaluate the overall regulatory and survey performance of The Villages of Orleans, a data analysis was conducted on key measures from April 2016 through February 2019. This information was obtained from operator supplied survey documents and Nursing Home Compare database as of February 28, 2019, which is the industry standard source for survey data. A summary of the survey detail can be found in **Exhibit 1.** The noteworthy findings of this report are detailed below.

An analysis of the total number of health deficiencies does not reflect any trends in the number of citations for The Villages of Orleans from 2016 through 2018, see table below for details. The

number of citations received during standard/annual surveys in 2016, 2017, and 2018 exceeded (negative variance) the state average.

There was one (1) survey which resulted in actual harm (G, H, I) citation during the three (3) year review period. The Villages of Orleans received one (1) "G" level citation during a complaint survey on 2/21/18, details of citations can be found in **Exhibit 2**. There were no open surveys at the time of the review, see **Exhibit 3.** The Villages of Orleans did not receive any actual harm citations in 2016 or 2017; however, the percentage of actual harm citations (G, H, I) was higher (negative variance) than the state average in 2018. The Villages of Orleans did not receive any immediate jeopardy citations in 2016, 2017, or 2018 which is lower (positive variance) than the state average for all three (3) years.

The average number of life safety survey (LSS) deficiencies for The Villages of Orleans was higher (negative variance) than the New York average in 2016, 2017, and 2018. All negative variances are noted in red.

	2016		2017		2018	
	Villages of Orleans	NY Average	Villages of Orleans	NY Average	Villages of Orleans	NY Average
Total Health Deficiencies	**14**	6.77	**7**	6.07	**11**	5.36
% of Citations – GHI level	0%	1.9%	0%	1.2%	**9.1%**	1.3%
% of Citations – JKL level	0%	1.1%	0%	1.1%	0%	0.5%
LSS Citations	**14**	3.3	**6**	3.7	**8**	4.8

The analysis conducted on the citations received during the three (3) year survey history resulted in a number of deficient practices which were written two (2) occasion(s).

F-Tag	Deficiency Description	# Citations
F282	Qualified Services in Accordance with Care Plan	2
F314	Treatment to Prevent/Heal Pressure Ulcers	2
F323	Facility Free of Accident Hazards	2

F514	Clinical Records Meet Professional Standards	2
F842	Resident Records – Identifiable Information	2
K521	HVAC	2
K918	Electrical Systems – Essential Electrical System Maintenance and Testing	2
K921	Electrical Equipment – Testing and Maintenance Requirements	2

A history of repeat deficient practices may be indicative of the facility not having appropriate systems in place to monitor regulatory standards. A detailed listing of all repeat citations can be found in **Exhibit 4**.

Based on discussions with facility leadership, they are following previous plans of correction to negate continued repeat noncompliance.

Remedies Imposed

Based on publicly available data during the three (3) year review period, The Villages of Orleans had one (1) per instance civil monetary penalty in the amount of $10,605.00 imposed by CMS as a result of adverse survey outcomes on February 21, 2018. The facility waived their right to appeal and the CMP was reduced to $6893.25. The CMP was paid on 8/2/18.

Special Focus Facilities

CMS' Special Focus Facility (SFF) program focuses on nursing homes that have a persistent record of poor performance and have often not addressed underlying systemic problems that result in repeated cycles of serious deficiencies and survey compliance issues.

According to CMS' SFF list published on January 1, 2019, The Villages of Orleans is not an SFF candidate nor on the SFF list. Details can be found in **Exhibit 5 and 6**

CMS Five-Star Ratings

The primary goal of the Five-Star Quality Rating System from CMS is to provide an easy way to understand nursing home quality and make meaningful distinctions between high and low performing nursing homes. The Five-Star system rates facilities in three (3) domains and also provides an overall star rating. A star rating of 1 or 2 stars is considered below average, 3 stars is average, 4 and 5 stars are above average.

On February 28, 2018, the Centers for Medicare & Medicaid Services (CMS) changed the health inspection domain methodology of the Five-Star rating system. In the previous methodology, CMS used a center's most recent *three* survey cycles in calculating the survey rating. In the updated methodology, CMS will use the most recent *two* survey cycles in calculating the survey rating. Additionally, as a result of the new survey process that was implemented effective November 28, 2017, CMS is holding constant the Health Inspection domain star ratings. Surveys occurring after November 28, 2017 will not be used in the determination of the health inspection star ratings until at least 12 months of data have been collected under the new survey process.

In April 2018 CMS published new Five-Star ratings which now utilizes Payroll-Based Journal (PBJ) staffing data to calculate the nurse staffing star ratings. In the past the staffing star ratings remained fairly stable since the data source was the CMS Form-671 and CMS Form-672 which each SNF completed at the time of their most recent standard survey. The new methodology uses the Payroll Based Journal (PBJ) submitted by each facility quarterly so there is the potential for star ratings to fluctuate more frequently as a result of quarterly updates to not only the quality measures but also the Nurse Staffing PBJ data.

On March 5, 2019 CMS released an update indicating changes to the Five-Star Quality Rating System. The changes include revisions to the inspection process, enhancement of new staffing information, and implementation of new quality measures; these changes have the potential to impact the facility Five-Star ratings beginning in April 2019.

Below are the average Five-Star ratings for the state of New York and a comparison of the current Five-Star ratings to the 12-month average for The Villages of Orleans and indication of whether there has been a trend noted for the facility in each of the Five-Star domains. Negative variances are noted in red.

	Overall	Health Inspection	Quality Measures	Nursing Staffing	RN Staffing
NY State Average	3.33	2.83	4.38	2.60	3.00
Villages of Orleans Current Five-Star Rating	**1.0**	**2.0**	**4.0**	**1.0**	**1.0**
Villages of Orleans 12-month Five Star Average Rating	1.0	2.0	3.25	1.0	1.0
Trend	No Trend	No Trend	Positive	No Trend	No Trend

As of February 1, 2019, The Villages of Orleans has an overall 1-star rating; the details can be found in **Exhibit 7.** There is not a documented Five-Star improvement plan for the facility. The health inspection domain includes two (2) years of survey data and will take time to show improvement. There are still areas for improvement that could potentially impact the overall star rating. The quality measure domain is easily modifiable. The Villages of Orleans has 11 quality measures (QMs) that have a negative variance to benchmark. An assessment of the residents along with a review of processes which impact the quality measure variables should occur, resulting in changes being implemented to achieve improvements in star ratings. The facility leadership states they have been reviewing the quality measures and implementing interventions to drive improvement which has resulted in positive outcomes as evidenced by an increase in the QM star rating from 3-stars in December 2018 to their current rating of 4-stars. The facility does not put in to place formal performance improvement plans, however, this is an area they intend to improve upon per Administrator. The facility remains a 1 star in the nurse staffing rating and may want to consider utilization of an outside recruiter, conduct a staff satisfaction survey to identify trends and implement a formalized staffing performance improvement plan to aid in driving improvement in this domain. Facility and their corporate office may want to review the PBJ data being submitted to CMS to ensure they have captured all nursing positions, including administrative nursing positions which are used in the calculation of the nurse staffing star rating.

Staffing

Payroll-Based Journal (PBJ) staffing data is submitted to CMS by each facility on a quarterly basis. Prior to April 2018 the staffing data source was CMS Form-671 and CMS Form-672 which each SNF completed at the time of their most recent standard survey. The new reporting methodology allows staffing and census information to be collected on a regular and more frequent basis than previously collected and offers greater specificity into actual hours spent on specific care related activities.

A staffing analysis was conducted utilizing data obtained through CMS and during an on-site visit. The Villages of Orleans is below (negative variance) both state/national averages for RN staffing and below (negative variance) national average for total nursing, see table below for details**.**

The Villages of Orleans Reported Staffing Hours / Resident / Day				Variance to State Average Reported Staffing Hours / Resident / Day				Variance to National Average Reported Staffing Hours / Resident / Day			
CNA	LPN	RN	Total Nursing	CNA	LPN	RN	Total Nursing	CNA	LPN	RN	Total Nursing
2.33	1.14	0.17	3.64	0.16	0.35	-0.49	0.02	0.12	0.31	-0.47	-0.04

Per on-site interview with facility leadership, The Villages of Orleans has utilized a staffing agency for years. In addition, they have implemented a Relocation Program in which they advertise out of state for both licensed nursing and CNA staff for nine (9) month contracts and pay their wages, housing, and transportation during this time frame. The Villages of Orleans advertise on Indeed, in the local paper, and on a local news hub online. Facility leadership state it is rare they receive applicants locally, thus the need to utilize a staffing agency and implement a Relocation Program. They also conduct job fairs and are a host for CNA training conducted by the Bureau of Cooperative Education twice a year. Their efforts for staff retention include occasionally providing food for staff and a benefits package that includes health, dental, vision, and life insurance. They also have a 401-K with the company matching 5% after two (2) years of employment.

Risk Management

HUD requires that Operators implement and maintain a risk management program which incorporates a real-time incident reporting and tracking system that informs Operator's senior management of all incidents with the potential to expose the Operator to liability for personal injury or other damages. Each incident must be reviewed by the Operator's appropriately-trained professional staff, and such staff must follow-up on incidents as necessary. The risk management program must include appropriate training for Operator's staff. For internal risk management programs, the Operator must incorporate a comprehensive software-based risk management program and have designated staff positions to implement the risk-management program

The Villages of Orleans meets the HUD Lean 232 definition of a Tier 1 risk level based upon receiving only one (1) G citation in the last three (3) years. The HUD Tier risk assessment can be found in **Exhibit 8,** Administrator and Director of Nursing resumes can be found in **Exhibit 9**.

The Villages of Orleans does not have a "real-time" incident/accident reporting system that informs senior management as indicated above in the HUD requirements. Per discussions with the facility leadership, in the event of a reportable incident/accident, facility staff notify the Director of Nursing (DON). Facility leadership state they handle these elevated events on a facility level and do not notify their corporate office. Based on the interview, the facility tracks and trends incidents and accidents on paper and appears to meet industry standards which includes review of incidents and accidents by date, time, individuals involved, as well as location of incident.

There appears to be two (2) active lawsuits against the property. Per review of the legal documents submitted for one (1) of the lawsuits, the facility is being sued for negligence related to dehydration, infection/sepsis, and pressure ulcer development that, per the plaintiff, lead to the resident's death on 4/9/17. The second lawsuit is between the facility and Freedom Therapy and Affinity Rehabilitation due to non-payment of therapy services in the amount of $54,502.98.

The Villages of Orleans has also received notice of a potential claim in which a resident fell from the bed sustaining a fractured nose. Medical records have been requested by an attorney representing the family. Per the DON, this was investigated by the state and found to be unsubstantiated. The Attorney General (AG) also came in to the facility a few months ago and requested records for this resident. The facility has not heard anything further from the AG. Due to the limited information Quality In-Cite received, it would be prudent for HHC Finance to complete further diligence into the issues regarding these pending cases to determine what financial risks may exist. See **Exhibit 10**.

In review of The Villages of Orleans QAPI program, they do not appear to meet the guidelines as set forth by CMS. CMS regulations require a facility maintain and demonstrate evidence of its ongoing QAPI program. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. Per interview with facility leadership, they currently are not implementing formalized performance improvement plans for issues and/or areas they may be trending in. The facility's QAPI policy and procedure states "*Concerns are brought up when a certain department or task is not hitting benchmark. The concern is discussed and an action plan developed."* Facility currently has multiple QMs above (negative variance) state and/or national benchmark with no performance improvement plans in place. The Administrator states they implement interventions to drive improvement but are not taking credit for it with a formalized performance plan. In addition, the facility only provided QAPI meeting minutes for March 2018, December 2018, and February 2019 for review. The QAPI meeting minutes are not comprehensive in nature and do not implement specific interventions based on negative variances in key performance areas such as falls, wounds, re-hospitalization, etc., nor discussion of performance improvement plans being implemented or monitored. The Medical Director and Pharmacy Consultant attend QAPI meetings 1-2 times per year instead of quarterly as per federal regulations.

PARA-SCOPE ®

The Villages of Orleans is rated at '**At Risk'** based on Quality In-Cite's proprietary risk tool **PARA-SCOPE®** which includes various limited available data from the last 12 months and last three (3) survey cycles. The drivers contributing to the risk rating are a harm level deficiency, total number of life safety deficiencies, CMPs, low CMS 5 Star ratings, and a 30% predictive likelihood of their rehospitalization rate being above 20.3%. Details in **Exhibit 11.**

Conclusion

As defined in our engagement agreement, an on-site review and analysis was performed to assess the overall clinical, regulatory, and operational performance for The Villages of Orleans.

The sources for this analysis included relevant operator reports, three (3) years of survey history, and CMS Five-Star Rating information available on the CMS/Data.gov web sites. We coupled these sources with our clinical and regulatory experience and knowledge. A major component of our report and assessment of The Villages of Orleans was obtained through on-site interviews with facility leadership. As a result of this analysis the overall clinical and regulatory risk assessment The Villages of Orleans appears to be 'At Risk'. Facility specific details, noteworthy findings, and facility specific recommendations for this facility can be found in the First Alert report, **Exhibit 12.**

QIC would also recommend the following to be considered by the facility and the owner/operator:

* Activity Director is not certified. Enroll Activity Director in a certification course and ensure follow up for Dietary Manager completing the Certified Dietary Manager course as required by Phase II RoP.
* Facility does not appear to be following their QAPI plan policy and procedure for implementing formalized performance improvement plans nor in compliance with federal regulations requiring the Medical Director and Pharmacy Consultant attending QAPI at a minimum of quarterly. Facility leadership should receive in-servicing regarding their QAPI program and regional/corporate follow-up ensuring these processes are followed.
* Review Phase III RoPs to ensure measures are being taken for successful implementation on November 28, 2019.
* Facility utilizing agency staff and paying relocation, housing, and transportation via a Relocation Program for nine (9) month contracts. Overtime is 6.9%. Implement a formal PIP and consider utilization of an outside recruiter to eliminate agency and the expense of the Relocation Program.
* Implement a weekly triple check system in which documentation is verified to support billing claims.
* Review restorative program components and consider having a dedicated restorative nurse and restorative aides to help drive improvement with QMs.
* Customer and staff satisfaction surveys are not currently being conducted. Develop a formal survey that can be provided to both short-term and long-term residents. Review results of surveys during QAPI and develop action plans as appropriate to address areas of concern.
* Elopement drills are conducted twice a year with facility having a Memory Care Unit. Consider conducting elopement drills across all shifts quarterly to mitigate risk.
* Door alarms are checked nightly by nursing staff but not documented. Consider having maintenance perform this task and document completion daily.
* DON states they utilize care pathways for infections and was not certain what mapping of infections entailed. Recommend infection control training for clinical leadership staff and implementation of either McGeer's or SHEA criteria as part of their infection control program and Antibiotic Stewardship.
* Facility does not conduct weekly risk meetings to discuss and review falls, infections, wounds,

behaviors, wt. loss, etc. but do discuss these in a daily stand up meeting. Facility's weight loss is 5%, wounds 7%, antipsychotic usage 13.8%, and anxiolytics/hypnotic usage 15.5%. Consider a comprehensive weekly risk meeting to review those residents that are triggering in high risk care areas to ensure resident condition is reviewed, and documentation, care plans, interventions, notifications, and orders are appropriate and implemented.

* Implementation of formalized PIPs with appropriate monitoring tools to decrease percentage of wt. loss, wounds, antipsychotics, and anxiolytic/hypnotics.
* Administrator states policies are not updated on an annual basis but on an as needed basis on the facility level. Implement annual review of policies and procedures with corporate review as well.
* The health inspection Five-Star rating has a 12-month average of 2.0. The facility leadership may want to consider conducting a root cause analysis of those areas identified with recurrent deficient practices and that have increased risk exposure and provide facility training related to policies and procedures, which incorporates best practices, to reduce the likelihood of further deficient practices and to mitigate potential for future risk.
* Nurse staffing and RN staffing Five-Star ratings are each 1-star. Review current staffing levels and conduct an analysis of resident acuity and dependency to ensure staffing is appropriate to meet the needs of the residents. Review PBJ data prior to submission to verify accuracy and allow for data to be corrected prior to next submission as this will affect the Five-Star rating and may lead to civil money penalties in the future.
* Facility does not have a real time incident reporting system that auto-generates alerts to inform facility leadership and senior management of incidents that increase liability exposure. Consider implementation of a real time incident reporting system with automated alerts to identified staff when incidents that could result in liability risk are entered to help mitigate facility exposure.
* Implementation of a comprehensive maintenance checklist to ensure routine monitoring to mitigate repeat life safety deficiencies.
* Obtain informed consents from residents and/or responsible parties prior to utilizing psychotropic medications.
* Administrator unable to give re-hospitalization rate. Implement monitoring for re-hospitalization rate as this effects Value Based Purchasing (VBP) which took effect in October 2018.
* Due to size of facility, consider adding a full-time Staff Development Coordinator to oversee training and in-servicing of staff.
* Facility currently utilizing PCC® for electronic health record. Continue with plans to implement EMAR/ETAR sooner rather than later.
* Consider Administrator and DON receiving formalized risk management training.
* Consider implementing daily administrative rounds sooner rather than later.
* Frequent regional/corporate oversight visits to ensure facility is following policies and procedures and regulatory requirements.
* New MDS nurse with no prior experience in completing MDS'. Consider regional/corporate support visits and review of coding to ensure accuracy. Also consider MDS nurse obtaining AANAC certification.

In this industry there are many acronyms utilized, we have made our best effort to define each as they are used in our report but have also included as **Exhibit 13** an Acronym Guide. We look forward to working with you on similar projects in the near future.

Sincerely,

The Quality In-Cite Team

EXHIBIT 43

POLARIS GROUP™
Strategic solutions for health care

30 YEARS POLARIS GROUP

The Villages of Orleans

3rd Party Risk Assessment - Clinical

Comprehensive at Orleans

14012 NY31/Eagle Harbor Road
Albion, NY 14111

Polaris Group Consultant: Renee Starling,RN, BSN, RAC-CT, IC-P

Polaris Group
3030 N. Rocky Point Drive, Suite 240
Tampa, FL 33607
800-275-6252

Distribution:
Jason Teitelbaum, Administrator

POLARIS GROUP™
Strategic solutions for health care

Facility Name:	**The Villages of Orleans**
Dates of Visit:	**June 23rd-25th, 2020**
Consultant Email:	[redacted] **Phone#:** [redacted]
FACILITY RISK LEVEL: (Low, Moderate, High):	**HIGH RISK LEVEL but has new leadership team 6.22.2020**

CARE AREA	SCORE
Pharmacy/Medication Management	3
Nutrition/Hydration	3
Skin/Wound/Pressure Ulcer	3
Complex Care Management	3
Incident Risk Management/ADLs	3
Abuse Reporting/Dignity	N/A
Infection Control	3
Change of Condition	3
MDS/Assessments	3
Care Planning	3
Resident Grooming/Dignity	1
Elopement Risk	3
Behavior/Dementia/Trauma Management	3
Restraint/Restrictive Side Rails	2
Pain Management	3
Bowel/Bladder	3
QAPI	3
Environmental/Emergency Controls	N/A
Medical Record	3
Physician Services	1
In-service/Orientation	1
Personnel Functions/Staffing	1

TOTAL CARE AREA SCORES:	
Low Risk (1)	4
Moderate Risk (2)	1
High Risk (3)	15

1= System in place (low risk)
2= Needs improvement; isolated negative outcomes (mod risk), negative outcomes
3= Pattern of breakdown in implementation; with or without negative outcome. (high risk)

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PRIORITIES FOR ACTION PLANNING	
1	**Notes:** - The Regional Administrator and DON just took over as new the administration for the facility starting on Monday, June 22, 2020. They are aware of the High Risk Areas as discussed in the exit interview. They have already initiated PIPs for those vulnerable areas. - The administrator and DON have started inservicing and training all staff on the Policy & Procedures for The Villages of Orleans. - The administrator and DON are in agreement for a follow-up visit in December of this year.
2	**Infection Control:** 1. Recommend the DON/ADON/Infection Control Nurse ensure all COVID-19 testing results are readily available and uploaded into the medical records ASAP to ensure COVID-19 results are being tracked and trended. 2. Residents who test Negative should have their orders discontinued for Isolation Precautions, Droplet Precautions, and Care Plans updated to reflect the changes in status of the COVID-19 residents. 3. Inservice Licensed nurses on properly initialing and dating all treatment dressings at the time of the dressing change.
3	**Incident Risk Management /ADLs:** 1. Review facilities P&P on Incident Reporting for reflecting planned practices by new team. 2. Ensure assessments are being completed for all incidents. Incorporate Fall, Braden, Pain and Elopement Assessments as part of the incident management program. 3. Recommend IDT Team review all incidents during morning meeting to ensure a complete clinical review was conducted and post incident interventions have been updated on the Care Plans & POC Kardex. 4. Inservice Licensed nurses on appropriate post incident charting every shift x 72 hours. 5. Recommend implementing a more formal RNP Program. 6. Recommend therapy screen those residents who trigger for ADL decline on a quarterly basis or when a significant change in ADL's occur.

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PRIORITIES FOR ACTION PLANNING	
4	**Care Planning:** 1. Recommend the IDT Team review those residents who trigger high on their QM report. Review the identified areas as listed on the QMs and ensure assessments have been completed, MD orders are not duplicated, appropriate diagnoses are in place, care plans and POC Kardex reviewed and updated, to reflect the appropriate plan of care. 2. The MDS Coordinator should provide the IDT Team Members with a copy of the most recent MDS Schedule and ensure all departments update their assessments according to the ARD. The IDT Team Members should review their care plans to ensure all interventions and goal dates have been reviewed and updated. 3. The IDT Team should review all new admissions for accuracy of assessments and new orders are reviewed and a Baseline Care Plan is in place.
5	**MDS/Assessments:** 1. IDT Team should review all new admits, re-admits and daily physician orders during morning meeting to ensure accuracy of assessments, care plans, and POC Kardex is reviewed and updated to provide safe and effective care. 2. Implement a monthly summary schedule according to those residents who are due for their Quarterly or Annual Assessment for nursing to complete prior to the ARD date. 3. Recommend the MDS Coordinator review resident records more carefully to ensure all areas of the MDS are captured and coded correctly.
6	**Nutrition/Hydration:** 1. Recommend dietician complete re-weigh when 3 pounds +or- discrepancy is noted. 2. Ensure admission, re-admission, quarterly and annual assessments are completed timely with proper dietary interventions for pressure ulcers listed and care planned. 3. Care plans should be revised during the MDS Observation period, with review of new orders, labs, or supplements. 4. Ensure weekly weights are being obtained as ordered by physicians with proper documentation of weight loss interventions and labs. 5. Review Tube Feeding orders to ensure there is no overlap of other meal times.

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PRIORITIES FOR ACTION PLANNING	
7	**Skin/Wound/Pressure Ulcers:** 1. Recommend implementing admission, re-admission, quarterly, significant changes and Annual Braden Scale Assessments. 2. Recommend IDT Team review High Risk Residents who have Pressure Ulcers weekly to ensure proper documentation is in place, care plans and POC Kardex updated to reflect new skin interventions; and, the MD and family are aware of treatment refusals. Care plans should be updated to reflect the residents behaviors on non-compliance of wound prevention and treatments. 3. The IDT Team should review daily skin checks at least weekly for omissions indicating not performed.
8	**Complex Care Management (diabetic, cardiac, I.V., tube feedings, Hospice, Dialysis):** 1. The DON should implement a better 24 hour communication form for all licensed nurses. 2. Recommend reviewing current residents who have pacemakers and ensure MD orders are in place including model & serial number and how often to check Pacemaker. 3. Registered Dietician should review weekly and monthly weights for accuracy. Re-weighs should be done when more than 3.0 lbs. discrepancy is noted. 4. Tube Feeding orders should be clarified when there is more than one diet order for Resident #6. 5. Resident #7: Must implement specific Dialysis orders for days, times, address, and phone number of center. • Should implement orders for monitoring of dialysis shunt for s/sx of infection. • Must implement dialysis communication form to be utilized for back and forth communications from center to center. • Need orders to hold medications or treatments on dialysis days. • Could send a snack or meal with resident on dialysis days. • Need a fall assessment for fall dated 6/5/2020. • Need a Braden Scale completed for newly In-House Unstageable Pressure Ulcer to the (R) Heel. 6. Consider a nursing admission assessment for when residents return from ER. 7. Need to review omissions in MARS/TARS for resident #6. Notify MD for all meds/tx that have not been given. 8. Review Resident #6 physician's orders to ensure meds have the appropriate diagnosis. 9. Need a Behavior Monitors, and side effect monitoring form for Remeron and Seroquel. Need an AIMS Assessment for Seroquel per your policy.

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PRIORITIES FOR ACTION PLANNING	
9	**Elopement Risk:** 1. Recommend the IDT Team review current residents to identify who may be at high risk for elopement. Implement Elopement Assessments for those identified during the audit. Ensure MD orders are obtained for those who require wanderguard. Care Plans and POC Kardex should be updated with the current findings. 2. Elopement Assessments should be completed upon admission, re-admission, quarterly, annually, or at any time change in condition occurs.
10	**Pharmacy Medication and Management:** 1. Pharmacy Consultant should review high risk medications monthly and PRN for appropriate diagnosis, reviewing BMF, and side effect monitoring to ensure all components are in place for high risk medications. 2. Recommend Social Services review current residents who receive any type of psychotropic medication and ensure a Consent has been signed, Behavior Monitor is in place to monitor for specific behaviors, side effect monitoring is in place, and non-pharmacological interventions are updated on the care plans. 3. Recommend the DON/ADON review the Clinical Dashboard daily in morning meeting to ensure all medications and treatments have been given as ordered and correct follow-up is in place for when omissions are identified. 4. Residents who receive anticoagulant therapy need to have a side effect monitoring in place, care plans, and POC Kardex should be updated to reflect high risk for bleeding and bruising.
11	**Behavior/ Dementia/ Trauma Psychotropic:** 1. Recommend Social Services implementing Phase 3 of Trauma Informed Care Plans. 2. Recommend S.S. update their care plans to include specific targeted behaviors to include non-pharmacological interventions on their care plans. 3. Review current listing of residents who receive psychotropic medications and obtain signed consents for the justification of use.

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PRIORITIES FOR ACTION PLANNING	
12	**Medical Record:** 1. Recommend the DON/ADON inservice licensed nurses on the policy and procedures of medication/treatment refusals and omissions. 2. Recommend the DON/ADON review the MARS /TARS daily for omissions in documentation with the proper notification to all parties.
13	**Pain Management:** 1. Review current residents and ensure a Pain Assessment has been completed. 2. Inservice Licensed nurses on completing pain assessments upon admission, re-admission, quarterly, annually, or when a new order is obtained for pain management. 3. Recommend DON/ADON review the daily dashboard to ensure residents pain is being monitored and controlled. 4. Care Plans should be reviewed and updated with daily orders.
14	**Bowel & Bladder:** 1. Recommend IDT Team review new admissions, re-admissions to ensure all Foley or Supra-Pubic Catheters have a size, balloon and Justification or diagnosis to support the use of Foley/ Supra-Pubic Catheters. 2. Ensure B&B assessments are completed according to centers P&P. 3. Care Plans should address size, balloon, and diagnosis for use, how often to change Foley, care of Foley. 4. POC Kardex should include care of Foley/Supra-Pubic Catheter for all direct care staff to know how to care for catheters. B&B Assessments should be completed upon admission, re-admission, quarterly, annually, or when a significant change in condition occurs.

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Facility Information

Section Title	Subject		
Visit Information	**Location**	**Findings**	**Additional Comments**
	Administrator Name	**Jason Teitelbaum, Administrator**	**Jason is the Regional Administrator and oversees the buildings in New York. He and the DON stepped into the administration role Monday, June 22, 2020.**
	Tenure at facility		
	Years experience in LTC		
	DON Name	**Carrie**	**DON is new and just started on June 22, 2020**
	Tenure at facility		
	Years experience in LTC		
	ADON/ Other Nurse Manager Name		
	Tenure at facility		
	Years experience in LTC		
	MDS Coordinator Name		
	Tenure at facility		
	Years experience in LTC		
	RN or LVN		
	MDS Coordinator 2 Name		
	Tenure at facility		
	Years experience in LTC		
	RN or LVN		
	Other/Infection Control Preventionist Name		
	Tenure at facility		
	Years experience in LTC		
Bed Capacity and Census	**Section Assessed**	**Findings**	**Additional Comments**
Based on data provided upon arrival.	**Total** number of Licensed Beds	120	
	Dual Certification: *(YES or NO)*	YES	
	Skilled Number Licensed:	120	
	Number Operational:	120	
	Average # of Medicare Admissions a Month:	10	
	Average Total # of Admissions a Month:	10	
	Specialty Unit?	**Dementia Locked Unit**	
	Other		

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Facility Information

Section Title	Subject		
Resident Information	**# of Residents that Are/Have:**	**Findings**	**Additional Comments**
Based on CMS 672 and Roster Matrix and observations.	Dialysis-Hemodialysis Peritoneal *(YES or NO)*	YES	
	Onsite?	OFF-SITE	
	Hospice *(YES or NO)*	YES	
	MR/ MI *(YES or NO)*	YES	
	Respite Care *(YES or NO)*	YES	
	Traumatic Brain Injury *(YES or NO)*	YES	
	Ventilator *(YES or NO)*	NO	
	Wound Care *(YES or NO)*	YES	
	Total # of Residents with Pressure Ulcers	2	According to the MDS 672 from PCC
	# Acquired Since Admission	0	According to the MDS 672 from PCC
	# Physical Restraints	0	According to the MDS 672 from PCC
	Type of Restraints	No restraints in use	According to the MDS 672 from PCC
	# of Restrictive Side Rails in Use	0	According to the MDS 672 from PCC
	# IV/ Parenteral	0	According to the MDS 672 from PCC
	# Tube Feedings	2	According to the MDS 672 from PCC
	# of Indwelling Catheters	1	According to the MDS 672 from PCC
	# with Unplanned Weight Loss	3	According to the MDS 672 from PCC
	# Mechanically Altered Diet	11	According to the MDS 672 from PCC
	# Tracheostomy/Suctioning	0	According to the MDS 672 from PCC
	# Respiratory/Oxygen	6	According to the MDS 672 from PCC
	# Ostomies	1	According to the MDS 672 from PCC
	# English is not Dominant Language	0	According to the MDS 672 from PCC

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3rd Party Risk Assessment - Clinical

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3 = Pattern of breakdown in implementation; with or without negative outcomes (high risk)

Category	Yes =Met, No=Not Met, NA= Not reviewed	
	General Comments	**Overview of Findings**
	Overall impression.	The facility has work ahead on educating staff on following the proper guidelines of facility admission assessments, post fall interventions and assessments, and updating care plans according to the MDS Schedule.
	Staff behaviors overall.	New Director of Nursing just started on June 22, 2020.
	Systems in place match other facilities?	The facility's clinical systems are not in place and lack the appropriate oversight for compliance with guidelines for assessments, post fall interventions, MDS Significant Changes in Conditions, and lack of IDT Team involvement in plan of care.
	Other	Treatment Carts observed unlocked with supplies left on top of cart. Treatments observed to be left at bedside of residents.

	Findings	Pharmacy/Medication Management	Overview of Findings
	No	Monthly pharmacy reviews with identification of high risk medications, appropriate duration, drug, dose, with follow-up with physician as indicated.	Pharmacy Consultant should review high risk medications monthly and PRN for appropriate diagnosis, reviewing BMF, and side effect monitoring to ensure all components are in place. Resident #8 - High risk medication: Xarelto; no side effect monitoring of bruising or bleeding.
	No	Evidence of monitoring to ensure accurate delivery, dispensing, and administration of drugs.	Resident #1- lacks Behavior Monitoring Form and Side Effect Monitoring for Anti-Depressant usage.
	Yes	Allergies are clearly communicated to all appropriate personnel.	
	No	Med/ treatment carts and rooms are equipped with locks and properly secured and stored.	Multiple Medication/Treatment Carts observed opened and unattended during the course of the three day visit.
	No	Meds and treatments documented/ given as ordered.	Resident #1- Multiple omissions in MARS/TARS without proper notification to MD.
	No	The physician is notified timely of omissions, refusals, and/or any delays in administration of medications or treatments.	Five out of five MARS/TARS had multiple omissions without MD notification
	N/A	Self-administration of drugs is by written physician authority and under facility control and supervision.	
	No	Physician orders followed in a timely manner i.e. labs, CBGs, INR monitoring, etc.	Resident #2- Could not locate the follow-up COVID-19 results in the medical record.
	No	Evidence that abnormal results are identified and reported to physician in a timely manner.	Five out of five residents re-tests for COVID-19 were not documented or scanned into the resident records.

SCORE:	**3**	1. Pharmacy Consultant should review high risk medications monthly and PRN for appropriate diagnosis, reviewing BMF, and side effect monitoring to ensure all components are in place for high risk medications. 2. Recommend Social Services review current residents who receive any type of psychotropic medication and ensure a Consent has been signed, BMF is in place to monitor for specific behaviors, side effect monitoring is in place and non-pharmacological interventions are updated on the care plans. 3. Recommend the DON/ADON review the Clinical Dashboard daily in morning meeting to ensure all medications and treatments have been given as ordered and correct follow-up is in place for when omissions are identified. 4. Residents who receive anticoagulant therapy need to have a side effect monitoring in place, care plans and POC Kardex should be updated to reflect high risk for bleeding and bruising.

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
Findings		**Nutrition/ Hydration**	**Overview of Findings**
	No	Dietary assessments and care plans complete and addressing risk factors.	Could not locate any dietary assessments or progress notes for Resident #1 who was re-admitted on 5/13/2020, with multiple pressure ulcers and documentation of inconsistencies in weights.
	Yes	Diet delivered as ordered (including thickened fluids).	
	Yes	Methods implemented to ensure swallowing precautions are followed by all staff.	
	No	Evidence of tube feeding delivery as ordered and adherence to schedule with oversight by RD.	Resident #6 - Has a G-Tube- Meds are ordered via Mouth/G-Tube. Recommend clarifying the route of all meds. Resident has two different diet orders and are spaced one hour apart.
	Yes	Dining assistance provided by staff or assistive devices per care plan.	
	No	Weights obtained upon admission. Weights documented as ordered/deviations from expected are communicated promptly and acted upon.	Resident #1- Admission weight on 5/14/2020 documented @ 246.0 via w/context weight dated 5/26/2020- 229.0 standing. Next weight dated 6/11/2020- 211.8 standing. Could not locate any notes from dietician on the inconsistencies with weight discrepancies. Resident #6- Inconsistencies with monthly weights and no re-weighs being done when discrepancies are noted.
	No	Nutrition at risk monitoring of high risk residents in place with revisions to care plan as indicated.	Could not locate any IDT Team documentation on weight loss prevention, inconsistencies in monthly weights.
		RECOMMENDATIONS	
SCORE:	**3**	1. Recommend dietician complete re-weights when 3 pound + or - discrepancies are noted. 2. Ensure admission, re-admission, quarterly and annual assessments are completed timely with proper dietary interventions for pressure ulcers. 3. Care plans should be revised during the MDS observation period with a review of new orders, labs or supplements. 4. Ensure weekly weights are being obtained as ordered by physicians with proper documentation of weight loss interventions and labs. 5. Review Tube Feeding orders to ensure there is no overlap of other meal times.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
Findings		**Skin/ Wound/Pressure Ulcer**	**Overview of Findings**
	No	QA oversight monitors effectiveness of wound/ pressure ulcer prevention.	
	Yes	Initial skin assessment was completed upon admission.	Resident#1 - Could not locate a Braden Scale, nursing note dated 5/13/2020
	No	Methods implemented to ensure risk factors are identified at admission, new wound/ pressure ulcer, and/ or at least a minimum of quarterly.	Could not locate any Braden Scale assessments. Resident #1- Could not locate a Braden Scale, nursing note dated 5/13/2020. Resident #1- Refusing Low Air Loss Mattress, could not find any documentation or care plan updated to reflect resident refusing skin prevention treatment.
	No	Detailed documentation upon discovery of new skin breakdown.	Inconsistencies in documentation of Pressure Ulcers.
	Yes	Physician/family notification is documented.	
	Yes	Method for skin checks in place.	Multiple weekly skin checks noted with omissions in documentation.
	Yes	Weekly measurements and progress evaluated with physician notification and Tx change if no progress is noted within 2 weeks.	Resident is being followed weekly by wound care team.
	No	Care Plan addresses risk factors and plans to prevent; updated interventions if new skin breakdown or new risk factors.	Resident #1- Re-admitted on 5/13/2020 with three new Pressure ulcers. Care Plans not updated to reflect the current status or post interventions for wound care.
		RECOMMENDATIONS	
SCORE:	**3**	1. Recommend implementing admission, re-admission, Quarterly, Significant Changes, and Annual Braden Scale Assessments. 2. Recommend IDT Team review High Risk Residents who have Pressure Ulcers weekly to ensure proper documentation is in place, care plans and POC Kardex updated to reflect new skin interventions and the MD and family is aware of treatment refusals and care plans updated to reflect the residents behaviors on non-compliance of wound prevention treatments. The IDT Team should review daily skin checks weekly for omissions.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
	Findings	**Complex Care Management (diabetic, cardiac, I.V., tube feedings, Hospice, Dialysis)**	**Overview of Findings**
	No	Procedures in place for monitoring complex risk care areas.	Resident #6- Inconsistencies in weights, need clarification of tube feeding orders. Meds have different routes of administration. Tube feeding formula left at bedside. Tube feeding syringe was not dated or labeled. No Admission Assessments or Quarterly Assessments being completed. No Elopement Assessment completed. No Post fall documentation or post fall interventions
	No	Procedures are followed related to complex care area.	Resident #5- has a Pacemaker Implant: No MD orders for type, model, serial number, or how often to check pacemaker.
	No	Evidence ordered labs are completed timely, and results acted upon.	
	No	Physician is notified in a timely manner if resident status is outside parameters.	
	N/A	Coordination with Hospice is evident in documentation/care plan.	No current residents on Hospice at the time of the visit
	No	Coordination with Dialysis is evident in documentation/care plan with oversight in place.	No dialysis orders for days, times, address, phone number. No orders for monitoring of shunt for s/sx of infection. No dialysis communication form being utilized back and forth for communication. No orders to hold medications or treatments on dialysis days. No snacks or meals being sent on dialysis days. No fall assessment for fall dated 6/5/2020. No nursing admission assessment when resident returned from ER. No Braden Scale completed for newly In-House Acquired Pressure Ulcer to the (R) Heel. Multiple omissions in MARS/TARS with no notification to MD on meds/tx not being given. No follow-up of orders Nebulizer Mouth piece at bedside was not bagged or labeled and sitting on top of dresser. Multiple medications noted in PCC with wrong diagnosis. No BMF, no side effect monitoring for Remeron or Seroquel. No AIMS for Seroquel. Inconsistencies noted in weights: standing vs. wheelchair. Missing weekly skin checks.
		RECOMMENDATIONS	
SCORE:	**3**	1. Recommend reviewing current residents who have pacemakers and ensure MD orders are in place including model & serial number, how often to check Pacemaker. 2. Registered Dietician should review weekly and monthly weights for accuracy. Re-weights should be done when more than 3.0 lbs. discrepancy is noted. Tube Feeding orders should be clarified when there is more than one diet order.	

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Category	Yes =Met, No=Not Met, NA= Not reviewed		
	Findings	**Incident Risk Management /ADLs**	**Overview of Findings**
	No	Incident reports are completed for all appropriate events including falls, elopements, skin tears, res to res altercations, other injuries or risk events	Resident #6- Has a wanderguard on and in place, no assessment has been completed quarterly or upon admission. Missing nursing documentation of post falls , incidents, bruises etc.
	No	Tracking and trending in place.	
	No	Evidence that IDT reviews incidents as part of Risk Management oversight.	Could not locate any notes in PCC for follow-up documentation from the IDT Team.
	No	Analysis monthly of trends includes types of incidents, location of incidents, day of week, time of day, other factors. Identifies repeat incidents for individual residents.	DON is new and could not locate any Monthly trends or Analysis.
	No	Timely reporting of incident, with thorough investigation documented, including interviews with all appropriate witnesses and resident, reaching a conclusion and action plan for that resident.	DON is new and could not locate any Monthly trends or Analysis.
	No	Timely reporting as required to state of any potential neglect/abuse events.	DON is new and could not locate any Monthly trends or Analysis.
	No	Complete documentation of the event including head/toe check, resident comments, and other appropriate clinical review.	Resident #1- Missing post fall nursing documentation x 72 hours.
	Yes	Evidence of timely notification of physician and family for any type of incident	
	No	Evidence of a post event summary in medical record and resulting care plan update	Could not locate any post fall interventions for Resident #1& #4.
	No	Fall risk assessments at time of admission, post fall, and at least quarterly with noted with care plan interventions	Could not locate any post fall assessments, quarterly or admission fall assessments. Resident #1- Sustained a fall dated 5/17/2020, no fall assessment completed, no pain assessment and care plan not updated to reflect post fall intervention.
	No	Restorative program in place. List all programs in place.	No formal RNP Program in place.
	No	ADL decline risk is care planned, and if decline occurs, timely referral to restorative/therapy and care plan update.	See above
	No	ROM is monitored and if decline occurs, timely referral to restorative/therapy and care plan update.	See above
	No	Restorative services are documented as provided per care plan.	See above
	No	Restorative care plan is in place, followed, and routinely reviewed.	See above
		RECOMMENDATIONS	
SCORE:	**3**	1. Review facilities P&P on Incident Reporting. 2. Ensure assessments are being completed for all incidents. Incorporate Fall, Braden, Pain and Elopement Assessments as part of the incident management program. 3. Recommend IDT Team review all incidents during am meeting to ensure a complete clinical review was conducted and post incident interventions have been updated on the Care Plans & POC Kardex. 4. Inservice Licensed nurses on appropriate post incident charting every shift x 72 hours. 5. Recommend implementing a formal RNP Program. 6. Recommend therapy screen those resident who trigger for ADL decline on a quarterly basis or when a significant change in ADL's occur.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
Findings		**Abuse Reporting/ Dignity**	**Overview of Findings**
	N/A	Abuse procedures include: 1) Screening, 2) Training, 3) Prevention, 4) Identification, 5) Investigation, 6) Protection, 7) Reporting.	The Regional Administrator and DON just took over as new administration for the facility on Monday, June 22, 2020. They are aware of the Abuse Reporting but due to the circumstances of the previous administration they were not able to readily locate any recent reports or investigation's.
	N/A	Evidence suspected abuse is identified and reported with immediate detailed investigation which describes alleged abuse and witness statements.	See above
	N/A	Evidence of determination of findings with corrective action plan noted.	See above
	N/A	Evidence of timely notification of physician and family.	See above
	N/A	Evidence of timely reporting as required by state.	See above
	N/A	Evidence of staff Abuse Training within last 12 months.	See above
		RECOMMENDATIONS	
SCORE:	**N/A**	1. The Regional Administrator and DON just took over as new administration for the facility on Monday, June 22, 2020. They are aware of the Abuse Reporting but due to the circumstances of the previous administration they were not able to readily locate any recent reports or investigations.	
Findings		**Infection Control**	**Overview of Findings**
	Yes	There is a functioning system to ensure all residents receive appropriate immunizations.	
	No	Evidence infections are identified, treated, tracked, and trended.	Resident #2- MD orders for Nasal Swab testing for COVID-19. No results noted in record. Activity documentation dated 6/22/2020 stated "resident participated in Bingo in activity room Residents were at least 6 feet apart at all times and were all masked in compliance with social distancing rules."
	N/A	Evidence of Infection Control Program includes COVID-19 Outbreak plans	I was not able to review this area was not able to review this area.
	N/A	Evidence of timely reporting of infections/outbreaks to Public Health, State, CDD; and Family/Residents/Reps.	I was not able to review this area.
	No	Evidence care plan is followed as ordered, and infection control practices are followed by staff based on observations	Resident #1- Care plans not revised or updated to reflect current plan of care. Resident has MD orders for Droplet Precautions and Isolation Precautions. No signage or Bins outside door. Resident is in room with another resident. Treatment dressings are not dated. Resident #6- Nebulizer tubing and mask lying on night stand with no bag, label, or date.
		RECOMMENDATIONS	
SCORE:	**3**	1. Recommend the DON/ADON/Infection Control Nurse ensure all COVID-19 testing results are readily available and uploaded into the medical records ASAP to ensure COVID-19 results are being tracked and trended. Residents who test Negative should have their orders discontinued for Isolation Precautions and Care Plans updated to reflect the changes in status of the COVID-19 residents. 2. Inservice Licensed nurses on properly initialing and dating all treatments as ordered.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
Findings		**Change of Condition**	**Overview of Findings**
	No	24-hour reporting system in place.	24-Hour report does not address pertinent changes in resident conditions.
	No	Assessment/findings in progress notes with timely follow-up and monitoring.	Resident #1- Assessments not completed for admission, no fall assessment completed for fall dated 5/17/2020. Missing 72 hour nursing monitoring for post fall.
	No	Timely notification of physician and family documented.	Could not locate follow-up on orders, changes in conditions to MD.
	Yes	Timely response from physician/NP with orders/visit as warranted.	
	No	Care plans revised as indicated.	Five out of five resident care plans have not been reviewed or revised during the most recent MDS Schedule.
	No	Documentation until resolved or physician updated to lack of progress.	Nursing documentation does not reflect current MD orders for discontinuing Isolation Precautions and MD orders.
	No	Specialty Care issues (e.g. vents, trachs, parenteral feedings, etc.)	Big issues noted with MD orders for Dialysis and Tube Feeding Residents.
		RECOMMENDATIONS	
SCORE:	**3**	1. The DON should implement a better 24 hour communication form for all licensed nurses. 2. Recommend reviewing current residents who have pacemakers and ensure MD orders are in place including model & serial number and how often to check Pacemaker. 3. Registered Dietician should review weekly and monthly weights for accuracy. Re-weighs should be done when more than 3.0 lbs. discrepancy is noted. 4. Tube Feeding orders should be clarified when there is more than one diet order for Resident #6. 5. Resident #7: Must implement specific Dialysis orders for days, times, address and phone number of center. - Should implement orders for monitoring of dialysis shunt for s/sx of infection. - Must implement dialysis communication form to be utilized for back and forth communications from center to center. - Need orders to hold medications or treatments on dialysis days. - Could send a snack or meal with resident on dialysis days. - Need a fall assessment for fall dated 6/5/2020. - Need a Braden Scale completed for newly In-House Unstageable Pressure Ulcer to the (R) Heel. 6. Consider a nursing admission assessment for when residents return from ER. 7. Need to review omissions in MARS/TARS for Resident #6. Notify MD for all meds/tx that have not been given. 8. Review Resident #6 physician's orders to ensure meds have the appropriate diagnosis. 9. Need a BMF, side effect monitoring form for Remeron and Seroquel. Need an AIMS Assessment for Seroquel per policy.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
	Findings	**MDS/ Assessments**	**Overview of Findings**
	No	Preliminary assessment upon admission is complete and appears accurate.	Resident #1- Admitted on 5/13/2020 with Pressure Ulcer to ® Heel, Pressure Ulcer to Sacrum and Pressure Ulcer to Left Heel. Section I was not coded with the Pressure Ulcers as a Primary Diagnosis. Section J1100- was not coded for Shortness of Breath. Section J 1700 did not code fall. Section O-0100 Section M- missed coding for Isolation Precautions. Resident #1- Should have had a Significant Change in Status completed for the MDS. No Admission Assessments are being completed upon admission or Quarterly.
	Yes	MDS completed per OBRA and PPS guidelines.	
	Yes	Compliance with Medicare requirements noted if audited resident is on Medicare.	
	Yes	CAAs documentation present and identifies risk factors for care planning.	
	No	Assessments by other disciplines performed and contribute to MDS coding (e.g. activities, social services, dietary, and other nursing assessments.)	Six out of six residents had no quarterly /admission, re-admission, sig change assessments completed in PCC or on paper.
	No	Monthly/weekly/quarterly summaries per procedures.	Could not locate any Monthly/Quarterly Summaries for five out of five resident records.
		RECOMMENDATIONS	
SCORE:	**3**	1. IDT Team should review all new admits, re-admits, and daily physicians orders during morning meeting to ensure for accuracy of assessments, care plans, and POC Kardex is reviewed and updated to provide safe and effective care. 2. Implement a monthly summary schedule according to those residents who are due for their Quarterly or Annual Assessments for nursing to complete prior to the ARD date. 3. Recommend the MDS Coordinator review resident records more carefully to ensure all areas of the MDS are captured and coded correctly.	
	Findings	**Care Planning**	**Overview of Findings**
	No	Timely and complete admission care plans address all high-risk areas.	Resident #1- Care plans not revised or updated to reflect current plan of care.
	No	Care plans are person-centered.	Care Plans are not resident specific and are generic.
	No	Timely identification of new or changed risk factors resulting in revision to the care plan.	Resident #1- Has new pressure ulcers and a recent fall. Care plans not updated to reflect post fall intervention or Pressure Ulcers.
	No	Interventions are added, changed, and reviewed at a minimum of quarterly.	Resident #1- Has new pressure ulcers and a recent fall. Care plans not updated to reflect post fall intervention or Pressure Ulcers.
	No	Evidence of direct care staff communication.	Care Plans and POC Kardex are not updated to reflect new orders or changes in conditions.
		RECOMMENDATIONS	
SCORE:	**3**	1. Recommend the IDT Team review those residents who trigger high on their QM report. Review the identified areas as listed on the QMs and ensure assessments have been completed, MD orders are not duplicated, appropriate diagnosis are in place, care plans and POC Kardex reviewed and updated to reflect the appropriate plan of care. 2. The MDS Coordinator should provide The IDT Team Members with a copy of the most recent MDS Schedule and assure all departments update their assessments according to the ARD. The IDT Team Members should review their care plans to ensure all interventions and goal dates have been reviewed and updated. 3. The IDT Team should review all new admissions for accuracy of assessments and new orders are reviewed and a Base since Care Plan is in place.	
	Findings	**Resident Grooming/ Dignity**	**Overview of Findings**

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3rd Party Risk Assessment - Clinical

1 = System in place (low risk), 2 = Needs improvement; isolated negative outcomes (mod risk),
3 = Pattern of breakdown in implementation; with or without negative outcomes (high risk)

Category		Yes =Met, No=Not Met, NA= Not reviewed	
	Yes	Residents appear groomed; facial hair, hair, nails.	
	Yes	Residents are dressed in a manner which provides privacy, dignity, and choice.	
	Yes	Staff treat residents with dignity and respect.	
	Yes	Resident preferences are allowed and privacy is maintained.	
		RECOMMENDATIONS	
SCORE:	1	No recommendations at this time.	
	Findings	**Elopement Risk**	**Overview of Findings**
	No	Method to identify elopement risk.	Resident #6- MD order for wanderguard. No assessments being done to determine at risk resident.
	N/A	"At risk" residents have care planning for elopement risk.	I was not able to review this area. Administrator and DON are aware of the findings.
	N/A	Environment includes safety measures/alarms to prevent elopement.	I was not able to review this area. Administrator and DON are aware of the findings.
		RECOMMENDATIONS	
SCORE:	3	1. Recommend the IDT Team review current residents to identify who may be at high risk for elopement. 2. Implement Elopement Assessments for those identified during the audit. Ensure MD orders are obtained for those who require wanderguard. Care Plans and POC Kardex should be updated with the current findings. 3. Elopement Assessments must be completed upon admission, re-admission, quarterly, annually or any time a change in condition occurs.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
	Findings	**Behavior/Dementia/Trauma Psychotropic**	**Overview of Findings**
	Yes	Drug Management in place	
	No	Assessments identify behavior/trauma triggers	Resident #1- Missing BMF for anti-depressant usage, no side effect monitoring, No Trauma care plans in place.
	No	Care plan addresses risk factors and include non-drug interventions.	Care Plans do not address non-pharmacological interventions or risk factors.
	No	Target behavior and side effects monitored per procedures.	No BMF could be located in PCC.
	No	Diagnosis and documentation support medical necessity of psychoactive medications.	No target BMF, no side-effect monitoring for anti-depressant usage for Resident #1 Resident #6- Inappropriate diagnosis for the use of Abilify. No AIMS, no BMF or Side Effect Monitoring, missing non-pharmacological interventions listed on care plans.
	No	Resident and family education and consents per procedures.	Could not locate any consents in PCC for any resident.
	Yes	Pharmacy monthly reviews with timely physician follow-up as indicated.	
	Yes	Reduction attempts noted per rules or rationale if not attempted.	
		RECOMMENDATIONS	
SCORE:	**3**	1. Recommend Social Services implementing Phase 3 of Trauma Informed Care Plans. 2. Recommend S.S. update their care plans to include specific targeted behaviors to include non-pharmacological interventions on their care plans. 3. Review current listing of residents who receive psychotropic medications and obtain signed consents for the justification of use.	
	Findings	**Restraint Management**	**Overview of Findings**
	No	Physician orders complete with medical symptoms and parameters for use.	Missing MD order for Scoop Mattress.
	N/A	Evidence of least restrictive and reduction.	
	N/A	Restraint as ordered with proper application.	
	No	Bed rail spacing meets safe parameters.	
	N/A	Consents per procedures.	
	No	Assessment and care plan complete.	No assessments completed for 1/4 side rails, transfer bars no orders.
		RECOMMENDATIONS	
SCORE:	**2**	Recommend implementing MD orders for all adaptive and specialty equipment. Care Plans and POC Kardex should be updated at the time of the orders.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
	Findings	**Pain Management**	**Overview of Findings**
	No	Pain screens/assessments upon admission, signs of pain, and at least quarterly.	Could Not locate Pain assessment for Resident #1 & #4.
	No	Pain monitoring daily.	Omissions in daily monitoring of pain
	No	Care plan addresses pain with drug and non-drug interventions. Non-drug interventions prior to drug use.	Pain care plans do not address non-pharmacological interventions.
	No	Evidence of pain management monitoring with timely revisions to care plan if ineffective pain control.	Care Plan not revised with M.D orders or changes in conditions with Resident #4.
		RECOMMENDATIONS	
SCORE:	**3**	1. Review current residents and ensure a Pain Assessment has been completed. 2. Inservice Licensed nurses on completing pain assessments upon admission, re-admission, quarterly, annually or when a new order is obtained for pain management. 3. Recommend DON/ADON review the daily dashboard to ensure residents pain is being monitored and controlled 4. Care Plans should be reviewed and updated with daily orders.	
	Findings	**Bowel/ Bladder**	**Overview of Findings**
	No	Bowel/bladder assessments at time of admission, incontinence, and at least quarterly.	Could not locate any B& B assessments.
	No	Process to identify toileting pattern resulting in a toileting plan	There is no forma Restorative Program un place for B&B training.
	No	Care plan addresses toileting plan.	Resident #1- Care plan does not address incontinence issues with B&B.
	No	Foley Catheters are justified and managed within standards of practice.	Resident # 5- No MD order for size or balloon of Supra-pubic Catheter.
		RECOMMENDATIONS	
SCORE:	**3**	1. Recommend IDT Team review new admissions, re-admissions to ensure all Foley and Supra-Pubic Catheters have a size, balloon, and justification or diagnosis to support the use of Foley or Supra-Pubic Catheters. 2. Ensure B&B assessments are completed according to centers P&P. 3. Care Plans should address size, balloon, and diagnosis for use, how often to change Foley, care of Foley. 4. POC Kardex should include care of Foley/Supra-Pubic Catheter for all direct care staff to know how to care for catheters. 5. B&B Assessments should due completed upon admission, re-admission, quarterly, annually or when a significant change in condition occurs.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
	Findings	**QAPI**	**Overview of Findings**
	No	Evidence Quality Assurance committee meets a minimum of quarterly with QAPI plan in place.	The Regional Administrator and DON just took over as new administration for the facility on Monday, June 22, 2020. They are aware of the Abuse Reporting but due to the circumstances of the previous administration they were not able to readily locate any recent reports or investigation's.
	No	Evidence risk management meetings occur a minimum of monthly.	See above
	Yes	Medical Director provides oversight for clinical programming and QA.	See above
	No	Evidence management is aware of areas of risk.	See above
		RECOMMENDATIONS	
SCORE:	**3**	1. The Regional Administrator and DON just took over as new administration for the facility on Monday, June 22, 2020. They are aware of the Abuse Reporting but due to the circumstances of the previous administration they were not able to locate any recent reports or investigations. 2. The Administration Team are in the process of revising all systems and opening up new PIPs for High Risk Areas as discussed and identified during their own system identification processes and the findings from this report.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
Findings		**Environmental/Emergency Controls**	**Overview of Findings**
		Drills	
	N/A	Evidence of fire drills.	
	N/A	Evidence of or planned Emergency/evacuation drills	
	N/A	Elopement drills	
		Smoking Controls	
	N/A	Smoking assessment or mandatory supervised smoking only per care plan and smoking policies; with protective devises is appropriate.	The facility does not have any residents that smoke.
		Oxygen Controls	
	Yes	Storage components are safe/ secure.	
		Hazards and Plans	
	N/A	System exists to identify physical hazards (self-inspection process).	
	N/A	Electrical outlets/cords do not cause risk.	
	N/A	Stairwell security.	One floor.
	No	Dangerous substances are secured.	Treatments left at bedside of residents. Treatment carts observed unlocked and treatments left on top of cart.
	N/A	Water temperatures/ call lights (signaling devices) are monitored and documented.	
	N/A	Emergency Plan current and known.	
	N/A	Emergency Plan includes emergency power.	
		RECOMMENDATIONS	
SCORE:	N/A	1. The Administration Team are in the process of revising all systems and opening up new PIPs for High Risk Areas as discussed and identified during their own system identification processes and the findings from this report. 2. Recommend inservicing Licensed Nurses on keeping all med/treatment carts locked at all times and not leaving treatments or wound care supplies at the bedside.	

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Category		Yes =Met, No=Not Met, NA= Not reviewed	
	Findings	**Medical Record**	**Overview of Findings**
	No	Overall documentation is within acceptable standards of practice.	Resident #1- Has multiple Omissions noted in MARS/TARS. Could not locate any MD of refusals or meds or treatments.
	No	Medication and Treatment records within acceptable standards.	Multiple Omissions in medications/treatments.
	No	Medical records are organized.	Could not locate any assessments in PCC or in resident records.
	Yes	Record integrity and secured storage in place.	
		RECOMMENDATIONS	
SCORE:	**3**	1. Recommend the DON/ADON in-service licensed nurses on the policy and procedures of medication refusals and omissions. 2. Recommend the DON/ADON review the MARS /TARS daily for omissions in documentation with the proper notification to all parties.	
	Findings	**Physician Services**	**Overview of Findings**
	Yes	System followed to ensure physician visits per requirements.	
	Yes	Medical Director in place.	
		RECOMMENDATIONS	
SCORE:	**1**	No recommendations at this time.	
	Findings	**In-service/ Orientation**	**Overview of Findings**
	Yes	A system exists to easily identify and retrieve proof of attendance at in-services; competency checks noted at hire.	
		RECOMMENDATIONS	
SCORE:	**1**	No recommendations at this time.	

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Category	Yes =Met, No=Not Met, NA= Not reviewed		
	Findings	**Personnel Functions/Staffing**	**Overview of Findings**
	No	Staffing seems to be sufficient based on schedule and observations.	The daily staffing board is not updated to reflect the current census, missing nursing and CNA assignments
	Yes	Use of temporary staff?	
	Yes	Evidence of attendance concerns/ overtime/ call-ins.	
	Yes	License/registry/Certificate checks for all staff	
	Yes	Background checks	
	Yes	Evidence of department competency reviews dietary, nurses, housekeeping. Nursing includes transfers and lifts (Hoyer) ongoing.	
		RECOMMENDATIONS	
SCORE:	**1**	Recommend updating Daily Staffing Board to include Date: Census: and assigned staff for the units.	

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	AUDIT FINDINGS
1	**Resident #1- Reviewed For Unstageable Pressure Ulcers, COVID-19, CPAP.** 1. Resident's MDS dated 5/29/2020- Multiple areas of missed coding. Section I, J and O. Did not code Pressure Ulcers under Primary Diagnosis, did not code shortness of breath or Isolation Precautions for COVID-19. 2. Resident sustained a fall and missed coding. Resident had a Significant Change In status. No MDS was completed. Inconsistencies with weights and re-weighs. Care Plan Goal due dates are Overdue and marked in RED. Care plans not updated to reflect current status of resident. No post fall interventions updated on care plans for fall dated on 5/17/2020. 3. No admission assessments completed, No BMF or Side Effect Monitoring for anti-depressant usage or anticoagulant. 4. MD ordered weekly weights every Monday/Thursday, weights not completed as ordered, no documentation where MD was notified of refusal.
2	**Resident #2- MD order for re-testing of COVID-19 on 6/12/2020. No results could be located in the record.** 1. MD orders for Droplet Precautions, no Isolation Bin outside door, No sign posted for Isolation Precautions, Activity documentation states "resident participated in Bingo in activity room, Residents were at least 6 feet apart at all times and were all masked in compliance with social distancing rules." MD Progress notes dated 6/16/2020 stated "resident recovered from COVID-19 and is back to her baseline status." Multiple omissions in MARS/TARS and POC Kardex. 2. No MD notification of omissions or refusals of medications or treatments. Missing non-pharmacological interventions on care plan, no BMF, or side effect monitoring for anti-depressant usage. Care Plans not updated with physicians orders.
3	**Resident #4- Multiple falls with no post fall interventions updated on care plans and POC Kardex.** 1. Many inconsistencies with monthly weights and lack of re-weighs and dietary interventions. Care plans not updated or revised with MDS Cycle, changes in conditions or revised with MD orders.
4	**Resident # 5- No MD orders for Supra-Pubic Catheter: missing size, and balloon.** 1. Treatments observed to be left at bedside of resident. No orders for Pacemaker.
5	1. Treatment Cart was observed on Orchid Unit to be left opened on several days and times during the visit. Treatment supplies left on top of cart. 2. Memory Care unit: nursing station doors left unlocked and opened the treatment cart unlocked and supplies noted on top of cart.

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AUDIT FINDINGS	
6	**Resident #6- Reviewed for Tube Feeding, Weight Loss, and falls. Re-admitted 4/24/2020: NO ADMISSION ASSESSMENTS COMPLETED UPON ENTRY INTO FACILITY.** 1. Resident has two diet orders and confusing as to which diet to provide. Inconsistencies in monthly weights, no re-weighs being conducted when weights vary. MD orders are conflicting: Some orders give by mouth some via g-tube. 2. Missing consents for Abilify, Ativan, Affordability: Inappropriate diagnosis, No AIMS, no BMF, no side effect monitoring, missing non-pharmacological interventions on care plans. 3. No Fall assessments for recent falls: dated 5/30/2020 & 6/6/2020. Missing 72 hour nursing documentation. Missing post fall interventions on care plans and POC Kardex. 4. No side effect monitoring of Coumadin in PCC. 5. Missing admission and quarterly Elopement Assessment: Resident has MD orders for wanderguard. 6. No order for Scoop Mattress. 7. MD orders for Isolation and Droplet Precautions: No Isolation Bin, No sign posted outside door for Isolation. Resident is out of room. 8. Orders need to be discontinued and care plans and POC Kardex updated. 9. Tube Feeding supplies in room not dated or labeled. Jevity left at bedside.
7	**Resident #7- Reviewed for Dialysis, falls, change in ADLs: NO ADMISSION ASSESSMENTS COMPLETED UPON ENTRY INTO FACILITY.** 1. No dialysis orders for days, times, address, phone number. 2. No orders for monitoring of shunt for s/sx of infection. 3. No dialysis communication form being utilized back and forth for communication. No orders to hold medications or treatments on dialysis days. 4. No snacks or meals being sent on dialysis days. 5. No fall assessment for fall dated 6/5/2020. 6. No nursing admission assessment when resident returned from ER. 7. No Braden Scale completed for newly In-House Acquired Pressure Ulcer to the (R) Heel. 8. Multiple Omissions in MARS/TARS with no notification to MD on meds/tx not being given. No follow-up of orders. 9. Nebulizer Mouth piece at bedside was not bagged or labeled and sitting on top of dresser. 10. Multiple medications noted in PCC with wrong diagnosis. 11. No BMF, no side effect monitoring for Remeron or Seroquel. No AIMS for Seroquel. 12. Inconsistencies noted in weights: standing vs, wheelchair. 13. Missing weekly skin checks.

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AUDIT FINDINGS	
8	**Resident #8- Reviewed for ostomy, chemo, port, and high risk medications:** 1. Nursing documentation continues to "state zinc sulfate 220mg- still not available." No notification to MD for this med not being available. 2. This is an OTC med, not sure why the cant not give this med. 3. Side effect monitoring for Xarelto. This is a High Risk Medication. 4. MD order for weekly weights, missing weekly weight. 5. MDS didn't capture Chemotherapy. 6. Care Plans not reviewed /revised during Quarterly MDS Cycle.

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End of Report

EXHIBIT 44

State of New York)
County of Orleans) ss:

I, Kathleen Howard, being duly sworn, depose and say:

1. I am the Director of Nursing for The Villages of Orleans Health & Rehab Center ("Villages"), located at 14012 Route 31 West, Albion New York. I have been so employed since 1/4/2021. Prior to that date, I served as the Assistant Director of Nursing beginning 12/20/2019

2. On or about March 17, 2021, the Villages received a subpoena duces tecum from the State of New York Office of the Attorney General, which includes a request for "[a]ll Accident and Incident reports and internal investigation reports (including witness statements/interviews) that were created after January 1, 2020."

3. Until June 2020, the Villages maintained Accident and Incident reports in hardcopy format only, in a basket located in an employee-only office space within the Villages facility. After receiving the subpoena, we discovered that the Accident and Incident reports, dated January 2020 through June 2020, as well as the basket in which the Villages normally maintained the reports, were missing.

4. My staff performed a thorough search of the entire facility and the missing records are nowhere to be found. Consequently, the Villages cannot produce all of the requested Accident and Incident reports, with a date range of January 2020 through June 2020, to the State.

5. As stated, the Villages maintained the subject Accident and Incident reports in hardcopy format only. The Villages started maintaining electronic Accident and Incident reports on or about June 21, 2020. Accordingly, the subject reports were not maintained within the Villages' electronic PointClickCare records.

Dated: August 13 2021

K. Howard, RN
Kathleen Howard

Sworn to before me this 13
day of August, 2021.

Annette Barone
Notary Public

ANNETTE BARONE
NOTARY PUBLIC-STATE OF NEW YORK
No. 01BA5013089
Qualified in Niagara County
My Commission Expires 07-15-2023

EXHIBIT 45

THE VILLAGES
OF ORLEANS

FACILITY ASSESSMENT TOOL

Persons – including names and titles – involved in completing this assessment	Administrator – Jason Teitelbaum Director of Nursing – Karrie Mikits Medical Director – Dr. Madejski RN Educator – Michelle
Date(s) of assessment updates	- 08/18/2017 - 11/15/2018 - 07/01/2019 - 03/01/2020
Date(s) of assessment review with QAPI committee	- 12/4/2018 - 06/19/2019 - 03/01/2020

Part 1: Facility Resident Profile

Numbers

1.1 Indicate the number of residents your license provide care for: 120

1.1.1 Long-term care beds 7: gardenview 12 semi private, 3 private, orchardview11 semi private, 2 private, canalview 12 semi private, 3 private 30 locked dementia bed, short-term care beds 12, 5 semi private 2 private

1.2 Indicate your average daily census: range (115 – not including march 2020 to june 2020 during pandemic)

1.2.1 Indicate average number of admissions made during the weekday: 0-2

1.2.2 Indicate average number of admissions made during the weekend-day: 0-1

1.2.3 Indicate average number of discharges made during the weekday:0-1

1.2.4 Indicate average number of discharges made during the weekend: 0-1

14012 NY-31, Albion, NY 14411 Phone: 585-589-3231 Fax: 585-589-6567

THE VILLAGES
OF ORLEANS

Diseases/Conditions, Physical and Cognitive Disabilities
Table 1: Disease and diagnosis

CATEGORY	COMMON DIAGNOSES
Psychiatric/mood disorders	Psychosis (Hallucinations, delusions, etc.) Impaired cognition, mental disorder, depression, bipolar disorder (i.e., mania/depression), schizophrenia, post-traumatic stress disorder, anxiety disorder, behavior that needs interventions, TBI with the behaviors
Heart/ circulatory systems	Congestive heart failure, coronary artery disease, angina, hypertension, orthostatic hypotension, peripheral vascular disease, risk for bleeding or blood clots comment deep venous thrombi basis(DVT), pulmonary thrombi embolism (PTE), pacemakers, cardiomegaly, syncope, heart block
Neurological system	Parkinson's disease, hemiparesis, hemiplegia, paraplegia, quadriplegia, multiple sclerosis, Alzheimer's disease, non-Alzheimer's dementia, seizure disorder, CVA, TIA, stroke, dramatic brain injury, Neuropathy, Down's syndrome, autism, Huntington's disease, Tourette's zero syndrome, aphasia, cerebral palsy
Vision	Visual loss, cataracts, glaucoma, macular degeneration
Hearing	Hearing loss, sign language
Musculoskeletal system	Fractures, osteoarthritis, other forms of arthritis, attraction
Neoplasm	Prostate cancer, breast cancer, lung cancer, colon cancer, other cancers not identified
Metabolic Disorders	Diabetes, thyroid disorders, hyponatremia, hyperkalemia, hyperlipidemia, obesity, morbid obesity
Respiratory Systems	Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, Chronic Lung Disease, Respiratory failure
Genitourinary System	Renal insufficiency, Nephropathy, Neurogenic bowel or bladder, renal failure, End stage renal disease, benign prosthetic hyperplasia, obstructive uropathy, urinary incontinence
Disease of Blood	Anemia, leukemia, compromised immune system, immunodeficiency
Digestive System	Gastroenteritis, cirrhosis, peptic ulcers, Gastroesophageal reflux, ulcerative Colitis,

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	Crohn's disease, inflammatory bowel disease, bowel incontinence, peg tubes, J tubes
Integumentary System	Skin ulcers, injuries, wound vac
Infectious Diseases	Skin and soft tissue infections, respiratory infections, tuberculosis, urinary tract infections, infections with multi drug resistant organisms, septicemia, viral hepatitis, clostridium deficit, influenza, scabies, legionellosis, VRE, MSSA

Decisions regarding caring for residents with conditions not found in table 1

1.2 Admissions are determined based on the facility coordinating with the IDT team including administrative offices. All admissions are accepted focusing that all resident's needs will be physically, clinically, and emotionally met. Holistic approaches are implemented and the facility focuses on patient centered care. All admission screens are reviewed and each resident is placed on a specific unit based on the acuity of the resident. In the event the facility would like to accept a new resident with a new diagnosis, all interventions skills will be reviewed and all staff involved in patient care it will be educated by either the DON, RN educator, or designee to determine if the facility can except the resident and focus on a positive outcome. In the event and resident resides in the facility and the new diagnosis has been identified the nursing team will collaborate with the medical staff and implement new interventions, maintaining safety and quality of care for that specific resident. All needs will be met including but not limited to equipment, transportation, and adaptive equipment.

Acuity

Table 2: Major RUG-IV Categories

MAJOR RUG-IV Categories	Number/Average or range of residents
Rehabilitation Plus extensive services	
Rehabilitation	
Extensive services	
Special care high	
Special care love	
Clinically complex	
Behavioral symptoms and cognitive performance	
Reduced physical function	

Table 3: Special Treatment and Conditions

	Special Treatment	Number/Average or range of residents
Cancer Treatments	Chemo Therapy	
	Radiation	

Respiratory Treatments	Oxygen Therapy	
	Suctioning	
	Tracheostomy	
	Ventilator or Respirator	
	BIPAP/CPAP	
Mental Health	Behavioral Health Needs	
	Active or Current Substance abuse disorders	
Other	IV Medications	
	Injections	
	Transfusions	
	Dialysis	
	Ostomy Care	
	Hospice Care	
	Respite Care	
	Solation or quarantine for active infectious disease	

Table 4: Assistance with Activity of Daily Living

Activity	# Independent	# Assist 1-2	# Dependent
Dressing			
Bathing			
Transfers			
Eating			
Toileting			
Other care if applic.			
	# Independent	**# with Assist Device used**	**# in chair, most of day**
Mobility			

Ethnic, Cultural, or religious factors
1.3 All ethnic, cultural and religious factors are implemented in the care and daily living provided to each resident. Activity focus is on each resident, religious and cultural needs. These needs are implemented in their decision based on the activities provided for all residents. Resident preferences specific to ethnic, cultural religious factors that may potentially affect the care provided to the resident are reviewed by the interdisciplinary care team. Examples may include but are not limited to; food and nutrition, languages, closing preferences, access to religious services, religious based advanced directives.

Other
1.4 Staffing will be adjusted to accommodate resident appointments. The facility shall enlist the help of family members both for transportation as well as assistance during travel.

THE VILLAGES
OF ORLEANS

Part 2: Facility Resident Profile

Resident Support/Care Needs

Table 5: Practices for specific care

General Care Practice	Specific Care Practices
Activities of Daily Living	Bathing, showers, oral/denture care, assistance or supervision while eating/drinking, auditory and/or visual needs, including glasses or hearing aids and communication boards, or sensory impairment
His/Herself	
Mobility and fall/fall with injury prevention	Transfers ambulation prevention of contractures
Bowel/Bladder	Incontinence care and prevention
Skin Integrity	Pressure injury prevention and care, skin care, wound care
Mental Health Behavior	Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior, identify any psychiatric diagnoses and any intellectual or developmental disabilities
Medications	By route, assessment and management of Polypharmacy
Pain Management	Assessment of pain; pharmacological and non-pharmacological pain management
Infection Prevention and control	Identification and containment of infections/Prevention of infections
Management of medical conditions	Assessments, early identification of problemsslashed terrier ration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease(COPD) gastroenteritis, infection such as UTI and gastroenteritis, pneumonia, hypothyroidism
Therapy	PT, OT; speech/language, music, management of braces/assist devices/splints
Other Special care needs	That dialysis, hospice, palliative care, ostomy, tracheostomy care, bariatric care, and End-of-life care
Nutrition	Nutritional balance, liberal diets, specialized diets, tube feeding, assistive devices, fluid monitoring or restrictions, hypo dermoclysis
Provide person-centered/directed care: psycho/social/spiritual support	Resident preferences and routines: Record and discuss treatment and care preferences's. Support emotional and mental well-being; support helpful coping mechanisms. Support RT resident having unfamiliar belongings. Provide culturally competent care: learn about the resident preferences and practices with regard to culture and

	religion; stay open two requests and preferences and work to support resident choices. Providing support access by the resident. Provide opportunities for social activities/life enrichment (Individually, in small groups, or within the community). Support community integration if resident desires. Prevent abuse and neglect. Identify hazards and risks for residents. Offer and assist resident and family caregivers (Or proxy as appropriate) to be involved in person– centered to care planning and or advanced directive planning. Provide family/representative with support.

Part 3: Facility Resources needed to provide competent support and care for our resident population every day and during emergencies

Staff Types

Table 6: List of Personnel includes but is not limited to

Administration staff developer, QA, infection control and prevention, environmental services, social services, admission/discharge planning, Business office, finance how my human resources, compliance, and ethics)
Nursing services (director of nurses, registered nurses, licensed practical nurses, certified nursing assistants, Health aides, and MDS nurses)
Food and nutrition services (Director, diet-tech, support staff, registered dietitian)
Therapy services (director, OT, OTA, PT, PTA, RT, speech language pathologist, audiologist optometrist activities professional activities staff and mental health social worker)
Medical/physician services (Medical director, attending physician, nurse practitioner, dentist, podiatrist, ophthalmologist, any ancillary physician services)
Pharmacist (outsourced)
Behavioral and mental health providers(outsourced)
Support staff (Environmental services/Housekeeping/laundry, maintenance)
Chaplin (Religious services, outsourced)
Volunteers Flash students
Other (vocational service workers, clinical laboratory services, diagnostics/X-ray, blood services)

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Staffing Plans

Table 7: Evaluation of necessary facility direct care providers to ensure residents needs are practicably met

Position	Total number needed or range*depending on census and acuity*
LPN	With avg. censes of 115 = 13-15/day 5 lpns on days and eve 4 lpns on nights
Certified Nurse Aides	With avg. censes of 115 = 28-30/day 10 cnas days – approx 1 on avs, 3 on avn, 2 on each village 10 cnas eve – – approx 1 on avs, 3 on avn, 2 on each village 6 cnas night
Other Nursing Personnel (administrative duties)	Mds= 2, ADON=1, DON=1
Behavioral healthcare professionals	Outsourced
Food Services	Dietician=1, diet tech=1, dietary manager=1

Table 8: General staffing plan to ensure residents needs are practicably met.

Staff Type	Plan
Licensed Nurses: RN, LPN,	Director of Nurse – RN full time days (may act as supervisor) Assistant Director of Nurses – If applicable full-time days (may act as unit manager) RN/LPN unit managers – 1 per unit FT/weekdays RN Supervisors – 1 per eve, 1 per night, 1 per days on weekends
Nurse Educator	RN educator/clinical educator – RN Part time flexes hours
Maintenance	Maint director – 1 FT flexes hours Maint assist (if applicable)– 1 PT
Enviro Services	Laundry services – 2 FT/days - 1 FT/eve Housekeeping – 4 FT/days – 1 FT/eve

Individual Staffing Assignments

3.1 individual staff assignments are identified and carried out on the units and are unit specific.

Staff Training and competencies at date of hire

3.2 Orientation review

3.2.1 Facility code of conduct

3.2.2 Dress code

3.2.3 emergency preparedness/review of emergency evacuation plan/Mutual aid plan/Fire safety

3.2.4 abuse/neglect and exploitation:

3.2.4.1 continuing nurse aide mandatory's and competencies (12 hours per year)

3.2.4.2 dementia management education

3.2.4.3 discussion of areas of weakness in performance reviews

3.2.4.4 provide services to residents with cognitive impairments

3.2.5 identification of resident changes in condition

3.2.6 cultural competency (to meet social, cultural, and linguistic needs of the resident)

3.2.7 HIPPA/password security

3.2.8 Hazardous substance/OSHA/MSDS

3.2.9 customer service/quality-of-life

3.2.10 employee accident prevention/no lift policy (Gate belts and prompt accident reporting)

3.2.11 procedure for reporting hypothermia

3.2.12 social media policy

3.2.13 Active shooter policy

3.2.14 hostile work environment/harassment/zero-tolerance

3.2.15 procedure for reporting changing condition

3.2.16 password security/documentation requirements

3.2.17 Reading and following the care plan

3.2.18 medication protocol (nurses only)

3.2.19 Pharmacy first dose in omnicell (Nurses only)

3.2.20 CNA skills and evaluation Foley care/incontinent care

3.2.21 medication administration and medication error review

3.2.22 reporting increases in pain and pain management

3.2.23 competency specific to licensed nurses

3.2.23.1 medication passes common treatment administration, and documentation of treatment preferences

3.2.23.2 ADL's (am./hs care, in continent care Incontinent care), ROM, dressings, feeding, oral care, transfers, gate belt, mechanical lifts

3.2.23.3 Disaster planning/procedure: Active shooter, elopement, fire, flood, power outage come tornado

3.2.23.4 Infection control– Hand hygiene, isolation, standard and universal precautions, M RSA/VER E/C diff precautions, environmental cleaning

3.2.23.5 Medication administration: injectable, oral, subcutaneous, topical

3.2.23.6 Measurements: BP, orthostatic BP, urinary output, height and weight, radio/apical holes, respirations, recording intake and output

3.2.23.7 Alzheimer's/dementia care

3.2.23.8 Specialized care: catheterization insertion/care, colostomy care, F SBS testing, oxygen administration, suction, tube feeding, wound care/dressings, dialysis care

3.2.23.9 mental and psychosocial disorders: implementing nonpharmacological interventions

Policies and Procedures for provisions of care

3.3 Policies and procedures are evaluated on a rolling basis, reviewed by the director of nurse and in-service educator, when review and education is needed, and/or must be provided to the staff. Policies and procedures, I reviewed by the director of nurses and in-service educator for accuracy and completeness to ensure they meet current professional standards of practice. The updated or new policy is reviewed an education provided to all indicated employees. The process to determine if new or updated policies are needed, include but are not limited to the review of standards of practice within the QA meeting and/or through identification in collaboration with the director of nurse's community.

Policies and procedures that have been updated in the last 30 days

Table 9: policy updates

NAME OF POLICY	CONFIRMED BY QA COMMITTEE/DON

Working with medical practitioners

3.4 The facility holds contracts with the following 3rd party practitioners, who are in constant contact with in house providers to ensure continuity of care

3.4.1 Team Health – Medical Director/NP

3.4.2 Family Choice – 3rd party NP/Physician

3.4.3 DentServe – dental care

3.4.4 Sightrite – ocular care

3.4.5 Podiatry – Dr. Gutsin

Part 4: Facility Physical Environment and Building/Plant Needs

Facility Structure

4.1 The facility is a two-story structure, comprised of a main building with 5 wings, a full working basement, attached and de-attached garages and a loading doc

4.1.1 Wing 1 sub-acute/rehab

4.1.2 Wing 2 subacute/rehab

4.1.3 Wing 5 LTC

4.1.4 Wing 6 LTC

4.1.5 The last wing is the kitchen and chapel/dining hall

4.2 Basement wings include:

4.2.1 Employee breakroom

4.2.2 Laundry room

4.2.3 Medical records overflow /storage

4.2.4 Maintenance shop/boiler room/loading dock

4.3 Facility vehicles include:

4.3.1 Pick-up truck with flat-bed and snow plow

Physical Equipment

4.4 Bathroom equipment

4.4.1 Bath Benches, Shower chairs, shower gurneys, bathing tubs, safety bars, sinks and toilets, scales

4.5 Room equipment

4.5.1 Beds (regular/bariatric), mattresses (air / regular), room furniture, wheel chairs, walkers, canes, air conditioners – if applicable

4.6 Assistive equipment

4.6.1 Any item may be purchased or rented if needed, lifts, slings, oxygen tanks, concentrators, exercise equipment

4.7 Medical equipment

4.7.1 Any item may be purchased or rented if needed, blood pressure monitors, compression garments, gloves, gowns, precaution/infection control products, heel and elbow suspension items, suction equipment, thermometers, urinary catheters, oxygen saturation machines, bi-pap, c-pap,

4.8 Services with equipment

4.8.1 Waste management, hazardous waste management, telephone (for subacute), HVAC, barber/beauty shop (separate entity from facility), court yard – lawn furniture

4.9 Elevator

Physical Vendor Contracts

5 See attached emergency /contracted vendors services document – Attachment 3

PECREE

6 See Pecree binder to identify specific beds/lifts/equipment and checked dates

Personal Protective Equipment

7 Personal Protective equipment shall consist of the following items

7.1.1 Items shall be made available in the event of an emergency, in the event residents are placed on isolation and in the event the interdisciplinary care team identify PPE is necessary. Certain PPE may not be necessary for certain types of isolation – items shall be determined by level of isolation; gowns and gloves shall be mandatory for all levels of isolation.

7.1.2 The facility shall ensure a par level at the time residents are placed on isolation as the level of precaution and the number of residents on precaution will affect the daily usage. The facility shall ensure that PPE shall be made available for residents on isolation.

7.2 Gowns

7.3 Gloves

7.4 Surgical Masks (N95's if applicable)

7.5 Goggles / Face masks

7.5.1 Ancillary PPE items may include stocks of; hand sanitizer, sani-wipes, isolation equipment (door hangers, isolation soiled item bags,

EXHIBIT 46

The Villages of Orleans Health and Rehabilitation Center
Policy and Procedure

Title:	STAFFING POLICY	Original Date of Issue: 3/10/20	Policy Number:
Section:		Date of Revision:	Page 1 of 2

OCNH Administrator:	Steve Hefter	Signature:
Medical Director:	Dr. Madejski	Signature:
Director of Nursing:	Debra Donnelly	Signature:
HR		Signature:

POLICY: This policy is in place to reflect the facility's protocol for ensuring safe staffing levels for holidays and weekends if applicable and for any other time as necessary.

PROCEDURE:

The facility shall confirm prior to holidays and if necessary, weekends, the front line (specifically clinical teams) staffing schedule is appropriately staffed in accordance with the facility assessment tool and the NYS DOH guidelines.

The scheduler shall be responsible for confirming the schedule with the Director of Nurses and the Administrator end. In the event the schedule does not appear to be complete, within regulation, the scheduler shall reach out to agencies to fill any open schedule holes as well as confirm with in-house employees whether they may be interested in picking up an open shift.

A call sheet for in-house and agency employees shall accompany the schedule for off shifts and weekend shifts

The schedule one the holiday or weekend begins shall be monitored by the supervisor along with any manger on duty if applicable. From shift to shift the supervisor shall identify whether certain employees, in accordance with the cba, will need to remain in the facility to support the resident population safely.

A "call-sheet" shall be used by the supervisor to place calls to employees who may want to come in to work to support the resident body. Agency contacts shall also be on the "call-sheet."

In the event the schedule is complete going into a holiday and or weekend, and due to call offs, safe staffing patterns no longer exist, the supervisor shall mandate staff in accordance with the department of labor.

The Supervisor shall notify the Director of Nurses and Administrator with the number of front-line clinical staff working and or expected to work on the upcoming shift.

EXHIBIT 47

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FACILITY ASSESSMENT TOOL

Persons involved in completing this assessment	Administrator – Eric R Flugel Director of Nursing – Kathleen Howard Medical Director – Dr. Madejski RN Educator – Stephanie Zalyski
Date(s) of assessment updates	- 08/18/2017 - 11/15/2018 - 07/01/2019 - 03/01/2020 - 03/17/2021
Date(s) of assessment review with QAPI committee	- 12/4/2018 - 06/19/2019 - 03/01/2020 - 03/17/2021

Part 1: Facility Resident Profile

	Current	12 month Average
Total residents	95	95.8
Total capacity (licensed beds)	120	
Short term rehabilitation Medicare beds	7	
Long term beds	108	
Long Term Private beds	10	
Dually Cert Beds	120	
Long Term Medicaid beds	108	

- Indicate average number of admissions made during the weekday: 0-2
- Indicate average number of admissions made during the weekend-day: 0-1
- Indicate average number of discharges made during the weekday:0-1
- Indicate average number of discharges made during the weekend: 0-1

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Diseases/Conditions, Physical and Cognitive Disabilities

Table 1: Disease and diagnosis

CATEGORY	COMMON DIAGNOSES
Psychiatric/mood disorders	Psychosis (Hallucinations, delusions, etc.) Impaired cognition, mental disorder, depression, bipolar disorder (i.e., mania/depression), schizophrenia, post-traumatic stress disorder, anxiety disorder, behavior that needs interventions, TBI with the behaviors
Heart/ circulatory systems	Congestive heart failure, coronary artery disease, angina, hypertension, orthostatic hypotension, peripheral vascular disease, risk for bleeding or blood clots comment deep venous thrombi basis(DVT), pulmonary thrombi embolism (PTE), pacemakers, cardiomegaly, syncope, heart block
Neurological system	Parkinson's disease, hemiparesis, hemiplegia, paraplegia, quadriplegia, multiple sclerosis, Alzheimer's disease, non-Alzheimer's dementia, seizure disorder, CVA, TIA, stroke, dramatic brain injury, Neuropathy, Down's syndrome, autism, Huntington's disease, Tourette's zero syndrome, aphasia, cerebral palsy
Vision	Visual loss, cataracts, glaucoma, macular degeneration
Hearing	Hearing loss, sign language
Musculoskeletal system	Fractures, osteoarthritis, other forms of arthritis, attraction
Neoplasm	Prostate cancer, breast cancer, lung cancer, colon cancer, other cancers not identified
Metabolic Disorders	Diabetes, thyroid disorders, hyponatremia, hyperkalemia, hyperlipidemia, obesity, morbid obesity
Respiratory Systems	Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, Chronic Lung Disease, Respiratory failure
Genitourinary System	Renal insufficiency, Nephropathy, Neurogenic bowel or bladder, renal failure, End stage renal disease, benign prosthetic hyperplasia, obstructive uropathy, urinary incontinence
Disease of Blood	Anemia, leukemia, compromised immune system, immunodeficiency
Digestive System	Gastroenteritis, cirrhosis, peptic ulcers,

	Gastroesophageal reflux, ulcerative Colitis, Crohn's disease, inflammatory bowel disease, bowel incontinence, peg tubes, J tubes
Integumentary System	Skin ulcers, injuries, wound vac
Infectious Diseases	Skin and soft tissue infections, respiratory infections, tuberculosis, urinary tract infections, infections with multi drug resistant organisms, septicemia, viral hepatitis, clostridium deficit, influenza, scabies, legionellosis, VRE, MSSA, COVID-19

Decisions regarding caring for residents with conditions not found in table 1

1.2 Admissions are determined based on the facility coordinating with the IDT team including administrative offices. All admissions are accepted upon determination that all resident's needs can and will be physically, clinically, and emotionally met. Holistic approaches are implemented and the facility focuses on patient centered care. All admission screens are reviewed and each resident is placed on a specific unit based on the acuity of the resident. In the event the facility would like to accept a new resident with a new diagnosis, all intervention(s) skills will be reviewed and all staff involved in patient care will be educated by either the DON, ADON, RN educator, or designee to determine if the facility can except the resident and focus on a positive outcome. In the event and resident resides in the facility and the new diagnosis has been identified the nursing team will collaborate with the medical staff and implement new interventions, maintaining safety and quality of care for that specific resident. All needs will be met including but not limited to equipment, transportation, and adaptive equipment.

Acuity

Special Treatment and Conditions

	Special Treatment	**Number/Average or range of residents**
Cancer Treatments	Chemo Therapy	0
	Radiation	0
Respiratory Treatments	Oxygen Therapy	
	Suctioning	0
	Tracheostomy	
	Ventilator or Respirator	
	BIPAP/CPAP	
Mental Health	Behavioral Health Needs	28
	Active or Current Substance abuse disorders	
Other	IV Medications	1
	Injections	20
	Transfusions	0
	Dialysis	1
	Ostomy Care	1
	Hospice Care	0

	Respite Care	0
	Solation or quarantine for active infectious disease	0
	Catheters	3
	Pressure Ulcers	13

Table 4: Assistance with Activity of Daily Living

Activity	**# Independent**	**# Assist 1-2**	**# Dependent**
Dressing	0	94	0
Bathing	7	33	46
Transfers	0	91	0
Eating	0	90	4
Toileting	0	94	0
Other care if applicable.			
	# Independent	**# with Assist Device used**	**# in chair, most of day**
Mobility	**1**	**50**	**74**

Ethnic, Cultural, or religious factors: All ethnic, cultural and religious factors are implemented in the care and daily living provided to each resident. Activity focus is on each resident, religious and cultural needs. These needs are implemented in their decision based on the activities provided for all residents. Resident preferences specific to ethnic, cultural religious factors that may potentially affect the care provided to the resident are reviewed by the interdisciplinary care team. Examples may include but are not limited to; food and nutrition, languages, closing preferences, access to religious services, religious based advanced directives.

Other
1.4 Staffing will be adjusted to accommodate resident appointments. The facility shall enlist the help of family members both for transportation as well as assistance during travel.

Part 2: Facility Resident Profile

Resident Support/Care Needs

Table 5: Practices for specific care

General Care Practice	**Specific Care Practices**

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Activities of Daily Living	Bathing, showers, oral/denture care, assistance or supervision while eating/drinking, auditory and/or visual needs, including glasses or hearing aids and communication boards, or sensory impairment
His/Herself	
Mobility and fall/fall with injury prevention	Transfers ambulation prevention of contractures
Bowel/Bladder	Incontinence care and prevention
Skin Integrity	Pressure injury prevention and care, skin care, wound care
Mental Health Behavior	Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior, identify any psychiatric diagnoses and any intellectual or developmental disabilities
Medications	By route, assessment and management of Polypharmacy
Pain Management	Assessment of pain; pharmacological and non-pharmacological pain management
Infection Prevention and control	Identification and containment of infections/Prevention of infections
Management of medical conditions	Assessments, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease(COPD) gastroenteritis, infection such as UTI and gastroenteritis, pneumonia, hypothyroidism
Therapy	PT, OT; speech/language, music, management of braces/assist devices/splints
Other Special care needs	Dialysis, hospice, palliative care, ostomy, tracheostomy care, bariatric care, and End-of-life care
Nutrition	Nutritional balance, liberal diets, specialized diets, tube feeding, assistive devices, fluid monitoring or restrictions, hypodermoclysis
Provide person-centered/directed care: psycho/social/spiritual support	Resident preferences and routines: Record and discuss treatment and care preferences. Support emotional and mental well-being; support helpful coping mechanisms. Support RT resident having unfamiliar belongings. Provide culturally competent care: learn about the resident preferences and practices with regard to culture and religion; stay open two requests and preferences and work to support resident choices. Providing support access by the resident. Provide opportunities for social activities/life enrichment (Individually, in small groups, or within the community). Support

	community integration if resident desires. Prevent abuse and neglect. Identify hazards and risks for residents. Offer and assist resident and family caregivers (Or proxy as appropriate) to be involved in person– centered to care planning and or advanced directive planning. Provide family/representative with support.

Part 3: Facility Resources needed to provide competent support and care for our resident population every day and during emergencies

Staff Types

Table 6: List of Personnel includes but is not limited to

Administration: Administrator, staff development, QAPI, infection control and prevention, environmental services, social services, admission/discharge planning, Business office, finance, human resources, compliance, and ethics
Nursing services: Director of Nurses, registered nurses, licensed practical nurses, certified nursing assistants, MDS nurse
Food and nutrition services: Director of Food Service, registered dietitian and support staff
Therapy services (director, OT, OTA, PT, PTA, speech language pathologist, audiology, optometry activities professional, activities staff
Medical/physician services (Medical director, attending physician, nurse practitioner, dentist, podiatrist, ophthalmologist
Pharmacist (outsourced)
Behavioral and mental health providers(outsourced)
Support staff: Environmental services/Housekeeping/laundry, maintenance
Religious services, (outsourced)
Volunteers Flash students
Other clinical laboratory services, diagnostics/X-ray, blood services

Staffing Plans

Table 7: Evaluation of necessary facility direct care providers to ensure residents needs are practicably met

Position	**Total number needed or range*depending on census and acuity***

LPN	With avg. census of 95 = 13-15/day 6 LPNs on days and eve 4 LPNs on nights
Certified Nurse Aides	With avg. census of 95 = 28-30/day 12-13 CNAs days 12-13 CNAs eve 7 CNAs night
Other Nursing Personnel (administrative duties)	MDS= 1, ADON=1, DON=1
Behavioral healthcare professionals	Outsourced
Food Services	Dietician=1 part time, dietary manager=1

Table 8: General staffing plan to ensure residents needs are practicably met.

Staff Type	**Plan**
Licensed Nurses: RN, LPN	Director of Nurse – RN full time days (may act as supervisor) Assistant Director of Nurses – RN full time days (may act as unit manager) RN/LPN unit managers – 1 per unit FT/weekdays RN Supervisors – 1 per eve, 1 per night, 1 per days on weekends
Nurse Educator	RN educator/clinical educator – RN Part time flex hours
Maintenance	Maintenance director – 1 FT flex hours Maint assist (if applicable)– 1 PT
Environmental Services	Housekeeping/Laundry services – 5 FT/7 PT days/eve

Individual Staffing Assignments

3.1 LPN Charge/Unit managers identify, assign and coordinate care staff keeping in mind continuity of care as possible.

Staff Training and competencies at date of hire

- Facility code of conduct/Dress code
- Resident Rights
- Abuse/neglect and exploitation
- Infection Control: Hand hygiene, standard/universal, isolation (respiratory/airborne/contact) precautions, MRSA/VRE/C-diff/COVID-19 precautions, environmental cleaning
- Emergency preparedness:
    - Fire Safety
    - Emergency response: Fire, Missing resident, Active Shooter, evacuation
- Corporate Compliance/HIPAA/Electronic Security
- Social media policy/Cell phone use/Photo/Video recording
- Workplace Safety:
    - Hazardous substance/OSHA/MSDS,
    - Safe Patient Handling/No lift policy/gait belt use
    - Accident/Incident reporting

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- Customer service/Quality-of-life and Cultural competency
- Trauma Informed and Dementia/Cognitive Impairment Care
- Clinical Competencies:
    - RN:
        - Supervisory duties and responsibilities
            - Accident/Incident Investigation and Reporting
            - Identification and reporting of resident changes in condition
            - Medication protocol/administration and error reporting
            - Emergency Response and/or Disaster planning/procedure: Active shooter, elopement, fire, flood, power outage come tornado
        - Resident assessment and examinations - admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment
        - Care Plan Development/Update
        - Behavioral/Mental and psychosocial disorders: assessment, identifying, reporting, development, and implementing nonpharmacological interventions as per plan of care
        - Clinical Competencies- per scope of practice
    - LPN
        - Resident observation and monitoring
            - Identification and reporting of resident changes in condition, pain management, abuse reporting
            - Contribution to development/revisions to resident's Plan of Care
        - Supervisory duties and responsibilities including:
            - CNA oversight/Assignment/Coordination of Care
            - Emergency Response and/or Disaster planning/procedure: Active shooter, elopement, fire, flood, power outage come tornado
        - Clinical Competencies- per scope of practice including medication protocol/administration (injectable, oral, subcutaneous, topical) and error reporting, commons treatment/wound care and documentation of treatment preferences
            - Specialized care: catheterization insertion/care, colostomy care, FSBS testing, oxygen administration, suction, tube feeding, wound care/dressings, dialysis care
            - Behavioral/Mental and psychosocial disorders: identifying, reporting and implementing nonpharmacological interventions as per plan of care
    - CNA
        - Reading and following the care plan
        - Foley care/incontinent care
        - Identification and reporting of resident pain and/or changes in condition
        - ADL's (am./hs care, in continent care Incontinent care), ROM, dressings, feeding, oral care, transfers, gate belt, mechanical lifts
        - Measurements: BP, orthostatic BP, urinary output, height and weight, radial/apical pulse respirations, recording intake and output
        - Behavioral/Mental and psychosocial disorders: implementing nonpharmacological interventions as per plan of care

Continuing Education (includes but not limited to) **:**

- All Staff – annual review of all mandatory topics including:
  - Infection Control
  - Fire Safety/Disaster Management
  - Corporate Compliance/HIPPA/Electronic Security
  - Resident Rights/Abuse Identification and Reporting
- CNA specific: mandatory and competencies (minimum-12 hours per year)
- Additional topics:
  - Person centered care
  - Trauma Informed Care
  - Dementia/Behavioral Care

Policies and Procedures for provisions of care

3.2 Policies and procedures are reviewed and evaluated on a rolling basis, reviewed by the Administrator, Director of Nurses for accuracy, completeness and to ensure they meet current professional standards of practice. When updates and/or education is needed it is provided by the in-service educator or appropriate designee to all indicated employees. The facility process to determine if new or updated policies are needed, include but are not limited to the identification of best practice as well as per directive from CMS or NYSDOH. The policy is then crafted in collaboration with the QA committee. Upon approval, all staff are educated by the in-service education or appropriate designee.

Policies and procedures that have been updated in the last 30 days

Table 9: policy updates

NAME OF POLICY	CONFIRMED BY QA COMMITTEE/DON
Infection Control/COVID-19	
Pandemic Emergency Plan - Update	
BLS/AED	

Working with medical practitioners

The administration reviews current medical services with the Medical Director and best practice to ensure residents have access to full complement of providers. The facility holds contracts with the following 3rd party practitioners, who are in constant contact with in house providers to ensure continuity of care. On admission and annually, residents/families are apprised of available contracted and specialty referral providers. As appropriate the medical director or specific provider participates in resident care rounds/care meetings.

- Team Health – Medical Director/NP
- Family Choice – 3rd party NP/Physician
- DentServe – dental care
- Sightrite – eye care

- Podiatry – Dr. Gutsin

Part 4: Facility Physical Environment and Building/Plant Needs

Physical Resource Category	**Resources**	**If applicable, process to ensure adequate supply, appropriate maintenance, replacement**
Buildings and/or other structures: One story structure	The Villages: • Orchard: 24 Beds • Canal 27 Beds • Garden 27 Beds Autumn View: • Memory/Dementia Care: # 30 beds • Subacute/Observation/Wing 12 beds Kitchen, Laundry, Rehab, Activity Employee breakroom, Medical Services hall Maintenance shop/boiler room/loading dock Administrative Hall: Administrative offices, Business office, Medical Records, Conference room.	
Vehicles	Transportation van, Pick-up truck with flat-bed and snow plow	
Physical equipment	Bath benches, shower chairs, bathroom safety bars, bathing tubs, sinks for residents and for staff, scales, wheelchairs and associated positioning devices, bariatric beds, bariatric wheelchairs, lifts, lift slings, bed frames, mattresses, room and common space furniture, exercise equipment, therapy tables/equipment, walkers, canes, nightlights, steam table, oxygen tanks/concentrators and tubing, See PECREE binder to identify specific beds/lifts/equipment and checked dates	
Services	Waste management, hazardous waste management, telephone, HVAC, dental, barber/beauty, pharmacy, laboratory, radiology, occupational, physical, and speech therapy, religious, recreational	
Other physical plant needs	ADA compliant entry/exit ways, nourishment accessibility, nurse call system, emergency power	
Medical supplies (if	Blood pressure monitors, compression garments, gloves,	

applicable)	gowns, hand sanitizer, gait belts, infection control products, heel and elbow suspension products, suction equipment, thermometers, urinary catheter supplies, oxygen, oxygen saturation machine, Bi-PAP, PPE: The facility maintains a 60 day supply of PPE at all times to comply with current infection control/pandemic emergency regulations. PPE includes: • Gowns • Gloves • Surgical Masks as well as N95's as applicable • Eye protection/Goggles • ABHS • Sanitizing wipes/cleaning solutions	
Non-medical supplies (if applicable)	Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices, computers	

3.9: List contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies.

- Agency Nursing Staff :
  - All agency staff are required to complete facility orientation prior to first assignment
- Snow Removal: county contractual agreement
- Mowing/Landscaping: county contractual agreement
- Hospice
- Laboratory
- Radiology
- Other: See emergency /contracted vendors in emergency management binder.

3.10: List health information technology resources:

- Facility utilizes Point Click Care (PCC) as EMR. When resident is transferred to the hospital, other SNF/Assisted Living facilities or discharged home, a discharge packet with pertinent information is sent to the receiving facility/agency or with the resident/designee.
- Residents/Designee or other entities may access medical records with proper consent
- In the event of computer outage or power failure PCC's back up system has been installed on unit specific computers.

3.11: Infection Control: The facility infection control policies and procedures include specific CDC guidance for staff on preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement. The infection control policy/procedures are reviewed and updated as per state and federal guidelines. Most recently to

include Emerging Infectious Disease and Pandemic Emergency Planning. The director of nursing is responsible for enforcing these policies.

3.12: Facility/Community Based Risk Assessment: - See Emergency/Disaster manual for most updated assessment

EXHIBIT 48

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING 01 - 1960 BLDG. B. WING _____	09/14/2020

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

(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) COMPLETE DATE
K 111 SS=E	NFPA 101 Building Rehabilitation Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This STANDARD is not met as evidenced by: Based on observations, interview and record review during the Life Safety Code survey	K 111	1. The fire barrier door between the penthouse and attic at the top of the stairs was repaired to self close and latch into its frame. The cross-corridor smoke barrier door at the entrance to "the villages" units was repaired to be self-closing and latch into its frame. The two-inch circular penetration through the fire barrier wall above the cross corridor door at the entrance to "the villages" units, was sealed. 2. An initial audit was completed by the director of maintenance or designee to identify fire barrier doors self-closing and latch into their frame. An initial audit was completed by the director of maintenance to ensure other fire barrier walls were properly sealed. 3. The Director of Maintenance was re-in serviced by the administrator the regulation to ensure fire barrier doors are self-closing doors latch into their frames and was inservice on smoke barrier walls are properly sealed. 4. The director of maintenance or designee shall audit, ongoing, monthly for fire barrier doors to ensure they are self-closing and latch into their frame. The director of maintenance or designee shall audit, ongoing, monthly for fire barrier walls to ensure they are properly sealed. 5. Audits shall be reviewed at the monthly QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	10/13/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	10/22/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING 01 - 1960 BLDG. B. WING _____	09/14/2020

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

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K 111	Continued From page 1 completed on 9/14/20, fire barriers that separated distinct construction types, were not properly maintained. Issues included fire barrier doors would not self-close and latch into their frames and a fire barrier wall was not complete from floor to ceiling/ roof deck, was not designed to have at least a two hour fire resistance rating, and was not designed to be resistant to smoke due to a penetration in the fire barrier. This affected two (fire barrier between the existing building and the 2006 addition and the fire barrier between the penthouse and the attic located above the Canal View unit) of four fire barriers. The findings are: 1a. Observation on the Canal View Unit on 9/8/20 at 11:05 AM revealed, the fire barrier door between the penthouse and the attic would not self-close and latch into its frame. Further observation revealed the attic had a wood floor and its roof was constructed of a wood deck with steel panel covering. During the observation the Director of Housekeeping/Laundry stated, he was not aware the door was not self-closing and latching into its frame. Review of documentation on file with the New York State Department of Health revealed the attic concealed space was separated from the resident units by (a five eighths inch gypsum board) one hour fire rated ceiling. b. Observation on 9/8/20 at 11:36 AM revealed two cross corridor fire barrier doors were installed in the corridor that separated the existing building and the 2006 addition. Further observation revealed the cross-corridor fire barrier door located closest to the employee locker room would not self-close and latch into its frame. During the observation the Director of	K 111		

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K 111	Continued From page 2 Housekeeping/Laundry stated, he was not aware the door was not self-closing and latching into its frame. Review of the facility floor plan at the time of the observation revealed the door was a fire barrier door. During an interview on 9/10/20 at 12:03 PM the Administrator stated, the fire barrier doors were checked during the smoke barrier wall inspections and the last inspection was conducted on 9/1/20. Review of the smoke barrier wall inspection form dated 9/1/20 revealed it contained no documentation that the fire barrier doors had been inspected. 2. Observation above the corridor ceiling tile on the Villages side of the corridor fire barrier wall between the existing building and the 2006 addition on 9/10/20 at 9:37 AM revealed a two inch circular penetration through the fire barrier wall above the fire barrier doors by the Villages dining room. During the observation the Director of Housekeeping/Laundry stated, the penetration needed to be sealed. Review of the facility floor plan at the time of the observation revealed this was a fire barrier wall. During an interview on 9/10/20 at 12:03 PM the Administrator stated, the fire barrier walls were inspected during the monthly smoke barrier walls inspections and the last inspection was conducted on 9/1/20. No work had been done on the fire barrier wall between the existing building and the 2006 addition. Review of the smoke barrier wall inspection form dated 9/1/20 revealed the smoke/fire barrier wall between the existing building and the 2006 addition had been inspected on 9/1/20.	K 111		

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K 111	Continued From page 3 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.1.1.4.1.1, 8.3, 8.3.1.1(2)(3), 8.3.3.1 2010 NFPA 80: 6.1.4.2, 6.1.4.2.1	K 111		
K 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222	1. A delayed egress sign indicating; "Push until alarm sounds door can be opened in 15 seconds," was placed on the exit door on Canal hall by resident room #36. A delayed egress sign indicating; "Push until alarm sounds door can be opened in 15 seconds," was placed on the exit door on Canal hall by resident room #22. A delayed egress sign indicating; "Push until alarm sounds door can be opened in 15 seconds," was placed on the exit door on garden hall by resident room #7. 2. An initial audit was completed by the director of maintenance or designee to ensure all doors with delayed egress locks were checked and have signage indicating instructions on the length of time needed to push on the door for the door to release safely. 3. The Director of Maintenance was re-in serviced by the administrator on the regulation to ensure all doors with delayed egress locks have signage indicating instructions on the length of time needed to push on the door for the door to release safely. 4. The director of maintenance or designee shall audit, ongoing, monthly, to ensure doors with egress locks have instructions on the length of time needed to push on the door for the door to release safely. 5. Audits shall be reviewed at the monthly QA meeting and confirmed to ensure compliance. The Administrator shall	10/13/2020

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K 222	Continued From page 4 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 9/14/20, doors equipped with delayed egress locks were not properly maintained. Issues included doors equipped with delayed egress locks lacked signage with instruction explaining how the doors could be opened in an emergency. This affected three (Canal View, Garden View and Orchard View units) of five resident units. The findings are: 1a. Observation on the Canal View unit on	K 222	be responsible for the implementation and evaluation of this corrective action.	

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K 222	Continued From page 5 9/10/20 at 10:54 AM revealed the exit door located near Resident Room #36 was equipped with a delayed egress lock. The door was not labeled with instructions stating "Push until alarm sounds door can be opened in 15 seconds." During the observation, the Director of Housekeeping/Laundry stated the door was equipped with a delayed egress lock and he was not sure why the door did not have a sign on it. b. Observation on the Canal View unit on 9/10/20 at 11:19 AM revealed the exit door located near Resident Room #22 was equipped with a delayed egress lock. The door was not labeled with instructions stating "Push until alarm sounds door can be opened in 15 seconds." c. Observation on the Garden View unit on 9/10/20 at 11:27 AM revealed the exit door located near Resident Room #7 was equipped with a delayed egress lock. The door was not labeled with instructions stating "Push until alarm sounds door can be opened in 15 seconds." During an interview on 9/10/20 at 12:52 PM the Administrator stated, the facility had no documentation for the inspection and testing of doors equipped with delayed egress locks. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.2.2.2.4(1)(2), 19.2.2.2.5, 19.2.2.2.6, 7.2.1.6.1, 7.2.1.6.1.1(4)	K 222		
K 225 SS=D	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225	1. The door leading to the basement from the therapy gym was repaired to be self-closing and latch into its frame. 2. An initial audit was completed by the Director of maintenance or designee to ensure stairway doors were self-closing and latch into their frame.	10/13/2020

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K 225	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 9/14/20, a stairway, that was used as an exit, was not properly maintained. Issues included, a stairway door that did not self-close and latch into its door frame. This affected one of one Basement and one of one attached Therapy rooms. The finding is: Observation in the Basement on 9/9/20 at 10:13 AM revealed the Basement stairway exit door would not self-close and latch into its door frame. Further observation revealed the door was hung-up on the door's frame resulting in a one-half inch gap between the door and its door frame. Continued observation revealed the Basement stairway exit door separated the Basement from the Therapy room located on the ground floor. The stairway door forms part of the compartment that separates the building's transfer switch equipment (for the building's emergency generator) from the Therapy room. During the observation the Director of Housekeeping/Laundry stated he was not aware the door was not self-closing. During an interview on 9/10/20 at 12:51 PM the Administrator stated, the facility did not have any documentation for the inspection and testing or the Basement stairway door. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 7.1, 7.1.3.2.1(1), 19.2.2.3, 7.2, 7.2.2, 7.2.1.1	K 225	3. The Director of Maintenance was re in serviced by the administrator the regulation to ensure stairway doors are self-closing doors latch into their frames. 4. The Director of Maintenance or designee shall audit, ongoing, monthly for stairway doors to be self-closing and latch into their frame. 5. Audits shall be reviewed at the monthly QA and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	
K 293 SS=E	NFPA 101 Exit Signage Exit Signage	K 293	1. Exit sign on autumn view north by the employee locker room was repaired to illuminate. The exit sign in the therapy	10/13/2020

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K 293	Continued From page 7 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observations, interview and record review during the Life Safety Code survey completed on 9/14/20, exit signs were not properly maintained. Issues included, exit signs were not illuminated. This affected one (Autumn View North) of five resident units, one of one therapy room and one of one mechanical rooms. The findings are: 1a. Observation on the Autumn View North Unit on 9/8/20 at 9:56 AM revealed the exit sign installed from the ceiling by the employee locker room was not illuminated. During the observation the Director of Housekeeping/Laundry stated, he was not aware the exit sign was not illuminated. b. Observation in the existing building's Therapy room on 9/8/20 at 10:06 AM revealed the exit sign located above the exit door near the basement was not illuminated. During the observation the Director of Housekeeping/Laundry stated, he was not sure how the long the exit sign had not been illuminated. c. Observation in the existing building's mechanical room located near the employee	K 293	room by the basement door was repaired to illuminate. The exit sign in the mechanical room was repaired to illuminate. 2. An initial audit was completed by the Director of maintenance or designee to ensure all exit signs were properly illuminated. 3. The director of maintenance was re in serviced by the administrator on the regulation to ensure exit signs are properly illuminated. 4. The Director of Maintenance or designee shall audit, ongoing, monthly to ensure exit signs are properly illuminated. 5. Audits shall be reviewed at the monthly QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 293	Continued From page 8 locker room on 9/8/20 at 11:40 AM revealed the exit sign located above the mechanical room's exit door, to the exterior of the building, was not illuminated. During the observation the Director of Housekeeping/Laundry stated, he was not aware the exit light was not illuminated. During an interview on 9/10/20 at 12:05 PM the Administrator stated, exit signs were checked during the monthly exit door audit and the last audit was on 9/1/20. Review of the monthly exit door audit dated 9/1/20 revealed it contained no documentation that exit signs had been checked as part of the audit. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.2.10.1, 7.10, 7.10.5, 7.10.5.1	K 293		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area	K 321	1. The clean utility room door on canal hall was repaired to be self-closing and latch into its frame. The clean utility room door on garden hall was repaired to be self-closing and latch into its frame. The service corridor door to the dry goods storage was repaired to be self-closing and latch into its frame. The brief storage room door was un-wedged. 2. An initial audit was completed by the Director of maintenance or designee to ensure hazardous area doors self close and latch into their frame and are not obstructed from closing. 3. The Director of Maintenance was re in serviced by the administrator the regulation to ensure hazardous area doors self close and latch into their frame and are not obstructed from closing. 4. The Director of Maintenance or designee shall audit, ongoing, monthly to	10/13/2020

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K 321	Continued From page 9 Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 9/14/20, hazardous area doors were not properly maintained. Issue included hazardous are doors did not self-close and latch into their frames and a hazardous area door was held open and obstructed from closing by devices that were not arranged to automatically close the door upon activation of the required manual fire alarm system, local smoke detectors, automatic sprinkler system, and loss of power. This affected two (Canal View and Garden View) of five resident units and one of one service corridor. The findings are: 1a. Observation on the Canal View Unit on 9/8/20 at 10:47 AM revealed the corridor door of the clean utility room would not self-close and latch into its frame. Further observation revealed the door's latch was covered with pieces of clear tape causing the door's latch to be held inside the door and the latch catch in the door's frame had been filled with paper towels. Continued observation revealed the room was greater than	K 321	ensure hazardous area doors self close and latch into their frame and are not obstructed from closing. 5. Audits shall be reviewed at the monthly QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 321	Continued From page 10 50 square feet in size and was being used to store a six foot tall by four foot long by two foot wide clean linen cart full of blankets, gowns, towels, face cloths and bed pads and a five foot tall by three foot long by two foot wide rack containing boxes of various medical supplies including but no limited to bubble humidifiers, oxygen tubing, oxygen masks, nasal cannulas and nebulizer kits. During the observation the Director of Housekeeping/Laundry stated, staff knew not to tape door latches or to put paper towels into the latch catches. b. Observation on the Garden View Unit 9/8/20 at 11:24 AM revealed the corridor door of the clean utility room would not self-close and latch into its frame. Further observation revealed the door's latch was covered with pieces of clear tape causing the door's latch to be held inside the door and the latch catch in the door's frame had been filled with paper towels. Continued observation revealed the room was greater than 50 square feet in size and was being used to store boxes of disposable briefs, vinyl gloves, a refrigerator, a mechanical lift and two trash receptacles. c. Observation on the service corridor on 9/8/20 at 11:51 AM revealed the corridor door of the dry goods storage/loading dock room would not self-close and latch into its frame. Further observation revealed the door was missing its latching mechanism. Continued observation revealed the room was greater than 50 square feet is size and contained over 100 cans of vegetables, fruit, and pudding, 17 boxes of tea, nine boxes of cake mix, five cases of cereal and three cases of potato chips. During the observation the Director of Housekeeping/Laundry stated, he was not aware the door's latch was missing.	K 321		

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(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) COMPLETE DATE
K 321	Continued From page 11 2a. Observation on the service corridor on 9/8/20 at 10:22 AM revealed the door to the brief storage room was equipped with a self-closing device. This door was being held in a fully open position by two cardboard boxes, that contained disposable briefs, that were wedged up against the door, holding the door in a fully opened position. Further observation revealed there were no staff working in the room. Continued observation revealed the room was greater than 50 square feet in size and contained over 50 cases of disposable briefs. During the observation, the Director of Housekeeping/Laundry stated this was the brief storage room. b. Observation on the service corridor on 9/10/20 at 8:40 AM revealed the door to the brief storage room was equipped with a self-closing device and the door was being held in a fully open position by two cardboard cases containing vinyl gloves and a five-foot-tall by three-foot-long by two-foot-wide cart full of packages of disposable briefs that were wedged against the door, holding the door in a fully opened position. Further observation revealed there were no staff working in the room. Continued observation revealed the room was greater than 50 square feet in size and contained over 50 cases of disposable briefs. During an interview on 9/10/20 12:07 PM the Administrator stated, the facility had no documentation for the inspecting and testing of hazardous area doors. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.2.2.2.7, 7.2.1.8.2, 19.3.2.1	K 321		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing	K 353	1. The facility's sprinkler vendor provided the facility spare sidewall	10/13/2020

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K 353	Continued From page 12 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 9/14/20, The automatic sprinkler system was not properly maintained. Issues included the facility did not maintain a spare supply of sprinkler heads that represent all types of sprinkler heads installed in the facility, the facility did not have the proper documentation for the types of sprinkler heads installed in the facility and sprinkler heads were coated with debris. This affected one of one supply of spare sprinkler heads, one (Autumn View North Unit) of five resident units and one of one kitchen. The findings are: 1a. Observations on 9/8/20 between 9:22 AM and 11:40 AM revealed side-wall sprinkler heads	K 353	sprinkler heads. A list of sprinkler heads was posted in the spare sprinkler room or at the sprinkler head riser. The sprinkler head in the tub room on Autumn View North hall was cleared of one-quarter inch thick layer of white debris. The sprinkler head in the corridor on autumn view north hall by resident room #225 was cleared of one-quarter inch thick layer of white debris. The sprinkler head in the kitchen near the tray line was cleared of one-quarter inch thick layer of black debris. 2. An initial audit was completed by the Director of maintenance and vendor services to ensure the facility had spare sprinkler heads for each type of sprinkler head installed in the building. An audit of all sprinkler heads installed to ensure they were not covered with debris. 3. The Director of Maintenance was re in serviced by the administrator the regulation to ensure a list of sprinkler heads are posted in the spare sprinkler room or at the sprinkler head riser. the director of maintenance was re inservice on the regulation to ensure spare sprinkler heads are available, for sprinkler heads installed in the building. the director of maintenance was re inservice on the regulation to ensure sprinkler heads were free from debris. 4. The Director of maintenance shall audit quarterly, with vendor services, to ensure a list of sprinkler heads is posted in the spare sprinkler room or at the sprinkler head riser. The Director of maintenance shall audit quarterly, with vendor services, to ensure spare sprinkler heads are available for each type of sprinkler head in the building. The Director of maintenance shall audit quarterly, with vendor services,	

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K 353	Continued From page 13 were installed in the Administration offices, Administrative corridor, Activities room, Therapy room, employee locker room and employee break room. Observation in the Basement on 9/8/20 at 10:16 AM revealed the facility's supply of spare sprinkler heads did not contain any sidewall style sprinkler heads. Further observation revealed there was no list of the types of sprinkler heads installed in the facility posted in the spare sprinkler cabinets or at the sprinkler system riser. During the observation the Director of Housekeeping /Laundry stated he was not aware of any other spare sprinkler heads in the building or a list of installed sprinkler heads. Review of wet fire sprinkler system inspection reports dated 2/14/20 and 9/5/19 revealed the following was written in the deficiency summary of the reports "No list of installed sprinkler heads at riser." 2a. Observation on the Autumn View North Unit on 9/8/20 at 9:34 AM revealed two pendent style sprinkler heads in the tub room were covered with a one-quarter inch thick layer of white colored debris. During the observation the Director of Housekeeping/Laundry stated the sprinkler heads needed to be cleaned. b. Observation on the Autumn View North Unit on 9/8/20 at 9:35 AM revealed one pendent style sprinkler head located in the corridor near Resident Room #225 was covered with a one-quarter inch thick layer of white colored debris. c. Observation in the Kitchen on 9/9/20 at 9:47 AM revealed two pendent style sprinkler heads located near the tray line were covered with a one-quarter inch thick layer of black colored	K 353	to ensure sprinkler heads are not covered with debris. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 353	Continued From page 14 debris. During an interview with the Administrator on 9/10/20 the Administrator stated the facility had no documentation for the cleaning of sprinkler heads or a list of sprinkler heads installed in the building. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 9.7.1, 9.7.1.1(1), 9.7.5, 9.7.6, 9.7.7 2010 NFPA 13: 6.2.9.7, 6.2.9.7.1 2011 NFPA 25: 5.2.1.1.2(5), 5.2.1.4, 5.4.1.4.1	K 353		
K 355 SS=E	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code Based on observation, interview and record review during the Life Safety Code survey completed on 9/14/20, portable fire extinguishers were not properly maintained. Issues included portable fire extinguishers were stored on the floor or were obstructed from immediate use. This affected one of one laundry room, one of one brief storage room and one (Canal View) of five resident units. The findings are: 1. Observation in the Activities room on 9/8/20 at 10:02 AM revealed a Class K fire extinguisher was stored on the floor between the oven and	K 355	1. The extinguisher located in the activity room was hung from a wall mounted bracket. The extinguisher located in the laundry room was unobstructed. The extinguisher located in the brief room was unobstructed. The extinguisher on canal hall by resident room #18 was unobstructed. 2. An initial audit was completed by the director of maintenance or designee to identify all extinguishers remained free from obstruction, hung from a wall mounted bracket or stored inside a fire extinguisher cabinet. 3. The Director of Maintenance was re in serviced by the administrator on the regulation to ensure all fire extinguishers were hung from a wall mounted bracket or stored inside a fire extinguisher cabinet. The maintenance director was in serviced to ensure fire extinguishers remained free from obstructions 4. The Director of Maintenance shall audit, ongoing, monthly to ensure used extinguishers are unobstructed and hung from a wall mounted bracket or stored inside a fire extinguisher cabinet. 5. Audits shall be reviewed at the	10/14/2020

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K 355	Continued From page 15 the refrigerator, instead of being hung from a wall mounted bracket or stored inside a fire extinguisher cabinet. During the observation, the Director of Housekeeping/Laundry stated he was not sure why the fire extinguisher was stored on the floor. Review of a fire extinguisher inspection list dated 8/2020 revealed no issues with the Class K fire extinguisher located in the Activities room. During an interview on 9/10/20 at 12:53 PM the Administrator stated, fire extinguishers were inspected monthly and the most recent inspection was conducted during August 2020. 2a. Observation in Laundry room on 9/8/20 at 10:34 AM revealed a five-foot-tall by three-foot-wide pedestal style fan, a three-foot-tall by three-foot-long by two-foot-wide laundry cart and a trash receptacle were obstructing the Class ABC fire extinguisher in the washing machine room. During the observation the Director of Housekeeping/Laundry stated, the fire extinguisher should not have been blocked. b. Observation on the service corridor on 9/10/20 at 8:40 AM revealed a five-foot-tall by three-foot-long by two-foot-wide cart full of disposable briefs was obstructing the Class ABC fire extinguisher located in the brief storage room. c. Observation on the Orchard View Unit on 9/9/20 at 9:19 AM revealed an over bedtable was obstructing the fire extinguisher and storage cabinet near Resident Room #18. During an interview on 9/10/20 at 12:53 PM the Administrator stated, fire extinguishers were inspected monthly and the most recent	K 355	QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 355	Continued From page 16 inspection was conducted during August 2020. Review of a fire extinguisher inspection list dated 8/2020 revealed no issues with the building's portable fire extinguishers. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.3.5.12, 9.7.4.1 2010 NFPA 10: 6.1.3.3, 6.1.3.3.1, 6.1.3.4(1)(2)(3)(4)	K 355		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are	K 363	1. The penetration through the corridor door, near the door handle to Resident room #217 was sealed. The penetration through the orchard hall medication room door, near the door handle was sealed. The penetration through the dietary office door, near the door handle, to the kitchen, was sealed. The corridor door on autumn view north hall to the employee locker room was repaired to latch into its frame. The corridor door to the communication room on the administrative hallway was repaired to latch into its frame. 2. An initial audit was completed by the director of maintenance or designee to ensure corridor doors were sealed, able to resist the passage of smoke. An initial audit was completed by the director of maintenance or designee to ensure corridor doors latch into their frame. 3. The director of maintenance was re in serviced by the administrator on the regulation of ensuring corridor doors were sealed, able to resist the passage of smoke and ensure they latch into their frame. 4. The Director of Maintenance shall audit, ongoing, monthly for corridor doors to be sealed, able to resist the passage of smoke and ensure they latch into their	10/13/2020

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K 363	Continued From page 17 allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 9/14/20, corridor doors were not properly maintained. Issues included, corridor doors were not designed to resist the passage of smoke and could not be latched into their door frames. This affected two (Autumn View North and Orchard View Units) of five resident units, one of one dietary office connected to the kitchen and one of one Administrative Wing. The findings are: 1a. Observation on the Autumn View North Unit on 9/8/20 at 9:34 AM revealed a one-inch long by one-quarter-inch wide perpetration through the corridor door of Resident Room #217. Further observation revealed the penetration was located above the door's handle. During the observation the Director of Housekeeping/Laundry stated he was not aware of the hole through the door. b. Observation on the Orchard View Unit on 9/8/20 at 11:21 AM revealed a one-quarter in circular perpetration through the corridor door of the Medication Storage room. Further observation revealed the penetration was located above the door's handle. During the	K 363	frame. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 363	Continued From page 18 observation the Director of Housekeeping/Laundry stated he was not aware of the hole through the door. c. Observation in the corridor between the Kitchen and the Activities room on 9/8/20 at 11:46 AM revealed a one-quarter inch circular penetration through the corridor door of the dietary office, that was connected to the Kitchen. Further observation at this time revealed the penetration was located above the door's handle. During an interview on 9/8/20 at 12:03 PM the Administrator stated the facility had no documentation for the inspection and testing of corridor doors. 2a. Observation on the Autumn View North Unit on 9/8/20 at 9:55 AM revealed the corridor door of the Employee Locker room would not latch into its door frame. During the observation, the Director of Housekeeping/Laundry stated he was not aware of any latching issues with this door. b. Observation on the Administrative Wing on 9/8/20 at 12:11 PM revealed the corridor door to the communication room would not latch into its door frame. During an interview on 9/8/20 at 12:03 PM the Administrator stated the facility had no documentation for the inspection and testing of corridor doors. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.6.3, 19.3.6.3.1, 19.3.6.3.5	K 363		
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie	K 372	1. The penetration through the smoke barrier wall between autumn view north and autumn view south halls by	10/13/2020

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K 372	Continued From page 19 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 9/14/20, a smoke barrier wall was not properly maintained. Issues included, a smoke barrier was not complete from floor to roof deck, was not designed to have at least a 30 minute fire resistance rating, and was not designed to be resistant to the passage of smoke due to a penetration through this smoke barrier wall. This affected two (Autumn View North and Autumn View South Units) of five resident units. The findings are: 1. Observation above the corridor ceiling tiles on the Autumn View South Unit on 9/8/20 at 1:33 PM revealed an eight-inch long by six-inch wide penetration through the smoke barrier wall above the cross-corridor smoke barrier doors by Resident Rooms 213 and 231. Further observation revealed this smoke barrier separated the Autumn View South Unit from the Autumn View North Unit. During the observation	K 372	resident room 213, was sealed. 2. An initial audit was completed by the director of maintenance or designee to ensure smoke barrier walls were properly sealed to have at least a 30 minute fire resistance rating. 3. The Director of Maintenance was re-in serviced by the administrator the regulation to ensure smoke barrier walls are properly sealed. 4. The director of maintenance or designee shall audit, ongoing, monthly for smoke barrier walls to ensure they are properly sealed. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 372	Continued From page 20 the Director of Housekeeping/Laundry stated, he was not aware of this penetration and this was the first time he had looked at the smoke barrier wall above the ceiling tiles. Review of the facility floor plan, at the time of this observation, confirmed this was a smoke barrier wall. During an interview on 9/10/20 at 12:03 PM, the Administrator stated the smoke barrier walls were inspected monthly and the last documented inspection was conducted on 9/1/20. Review of the smoke barrier wall inspection form dated 9/1/20 revealed the smoke barrier wall that separated the Autumn View South Unit from the Autumn View North had been inspected on 9/1/20. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.3.7.3, 8.5, 8.5.1, 8.5.2, 8.5.2.1, 8.5.2.2, 8.5.2.3	K 372		
K 712 SS=E	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on interview and record review during the Life Safety Code survey completed on 9/14/20,	K 712	1. The facility IDT team, including administrator and director of maintenance, reviewed the policy and procedure and regulation for completing fire drills. The facility created a schedule by which fire drills would be conducted once quarterly on each shift. A fire drill was completed. 2. The facility IDT team created a schedule by which fire drills would be conducted at least quarterly on each shift. 3. The director of maintenance was re in serviced by the administrator on the regulation for conducting fire drills at least quarterly on each shift. 4. Fire drills shall be confirmed at the QA meeting which occurs in the middle of the month, and in the event, it has not yet been completed, would leave time for substantial completion.	10/09/2020

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K 712	Continued From page 21 the facility did not conduct fire drills at least once, per shift, per quarter. This affected five (Autumn View North, Autumn View South, Canal View, Garden View and Orchard View Units) of five resident units. The findings are: Review of fire drill evaluation reports revealed: - For the purposes of conducting fire drills, the facility identified staff shifts as follows: First Shift (7:00 AM to 3:00 PM), Second Shift (3:00 PM to 11:00 PM), Third Shift (11:00 PM to 7:00 PM). - January, February and March of 2019: The facility had no documentation that fire drills were conducted on the First, Second and Third shifts. - April, May and June of 2019: The facility had no documentation that fire drills were conducted on the First shift . - January through September of 2020: The facility had no documentation that fire drills were conducted on the First, Second and Third shifts. During an interview on 9/10/20 at 12:53 PM, the Administrator stated the facility had no other fire drill evaluation reports, other than the reports that had been provided. The Administrator further stated fire drills were not being conducted. When the Administrator was asked if there were any reasons why fire drills were not being conducted, he stated "No." 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 101: 19.7.1.6	K 712	5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	
K 911 SS=E	NFPA 101 Electrical Systems - Other Electrical Systems - Other	K 911	1. The cover plate from the electrical junction box in autumn north hall tub room was replaced. The cover plate from the	10/13/2020

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K 911	Continued From page 22 List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 9/14/20, electrical junction boxes, electrical duplex outlets and light switches were not properly maintained. Issues included electrical junction boxes and electrical duplex outlets were missing their coverplates and light switch covers were cracked. This affected two (Autumn View North and Garden View Units) and one Therapy room in the existing building. The findings are: 1a. Observation on the Autumn View North Unit on 9/8/20 at 9:33 AM revealed the cover plate was missing from an electrical junction box in the tub room. During the observation the Director of Housekeeping/Laundry stated, someone must have been working in the room. Further observation at this time revealed no staff or residents were in the room. b. Observation in the existing building Therapy room on 9/8/20 at 10:06 AM revealed the cover plate was missing from a duplex electrical outlet. Further observation revealed the outlet was supplying power to a power strip, a television and cellular phone charger. During the observation the Director of Housekeeping/Laundry stated, he was not aware the outlet's cover was missing.	K 911	duplex electrical outlet in the therapy room was replaced. The two cover plates from the two electrical junction boxes at the aide's station on garden hall were replaced. The light switch cover in room #224 on autumn view north hall was replaced. The light switch cover in room #223 on autumn view north hall was replaced. 2. An initial audit was conducted by the director of maintenance or designee to ensure electrical junction boxes, electrical duplex boxes, had properly installed cover plates. An initial audit was conducted by the director of maintenance or designee to ensure light switches were not cracked. 3. The director of maintenance was re in serviced by the administrator on the regulation to ensure electrical junction boxes, electrical duplex boxes, had properly installed cover plates. The director of maintenance was re in serviced by the administrator on the regulation to ensure light switches were not cracked. 4. The director of maintenance shall audit weekly for 4 weeks and monthly for 2 months to identify electrical junction boxes, electrical duplex boxes, and light switches were properly maintained. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action	

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K 911	Continued From page 23 c. Observation on the Garden View Unit on 9/8/20 at 11:26 AM revealed the cover plates were missing from two electrical junction boxes located at the Aide's station. 2a. Observation on the Autumn View North Unit on 9/8/20 at 9:42 AM revealed a two inch long by quarter inch wide and two, one inch long by quarter inch wide cracks in the light switch cover in Resident Room #224. During the observation the Director of Housekeeping/Laundry stated he was not aware of the cracks in the light switch cover. b. Observation on the Autumn View North Unit on 9/8/20 at 9:42 AM revealed a one inch long by quarter inch wide crack in the light switch cover in Resident Room #223. During an interview on 9/10/20 at 12:55 PM the Administrator stated, the facility had no documentation for auditing the facility's junction boxes, outlets or light switches. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 99: 6.1, 6.1.1, 1.3, 1.3.2.1, 6.3.2, 6.3.2.1, 2011 NFPA 70: 110.3(A)(2)(8), 314.25, 314.72(C), 406.6	K 911		
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and	K 918	1. The QA team including the administrator and director of maintenance, identified previous months without checks, and instituted monthly load tests and weekly inspection checks, as of July 2020. The weekly inspection has been conducted on the two emergency generators. The monthly load test has been conducted on the two emergency generators under the guidance of key power - vended service. 2. An initial audit was conducted by	10/13/2020

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K 918	Continued From page 24 critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observation, interview and record review during the Life Safety Code survey completed on 9/14/20, the emergency generators were not properly maintained. Issues included, the facility did not have documented evidence that the emergency generators were exercised under load for at least 30 minutes on a monthly basis and were inspected on a weekly basis. This affected two (generator #1 and generator #2) of two emergency generators. The findings are:	K 918	the director of maintenance or designee to confirm the generators had all working parts and were able to be started on load tests - under the guidance of key power - vended service. 3. The director of maintenance and administrator shall re in serviced in October 2020, by keypower - vended service, whom are contracted to inspect the emergency generators, on the regulation indicating generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. 4. The director of maintenance or designee shall audit, ongoing, monthly for under load 30 minutes. The director of maintenance or designee shall audit, ongoing, weekly for generator inspection. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 918	Continued From page 25 Observation on 9/9/20 at 9:32 AM revealed the facility was served by two emergency generators, installed at the exterior of the facillity 1) Emergency Generator #1: a) Review of the facility's emergency generator monthly test logs for generator #1 revealed no documented evidence that monthly load tests were conducted during March, April, May, June, July, August and September of 2019. b) Review of the emergency generator weekly inspection audits for generator #1 revealed the audits contained no documented evidence that weekly inspections were conducted during January, February, March, April, May, June, July of 2019. 2) Emergency Generator #2 a) Review of the facility's emergency generator monthly test logs for generator #2 revealed the logs contained no documented evidence that monthly load tests were conducted during March, April, May, June, July, August and September of 2019. b) Review of the facility's emergency generator weekly audits for generator #2 revealed the audits contained no documented evidence that weekly inspections were conducted for January, February, March, April, May, June, July of 2019. 3) Per the 2012 edition of NFPA99, Health Care Facilites Code: Scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. During an interview on 9/10/20, the Director of Housekeeping/Laundry stated monthly load tests on emergency generator #1 and emergency generator #2 were done automatically every Wednesday and none of the	K 918		

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K 918	Continued From page 26 facility's staff were manually transferring the generator's transfer switches based on this interview, a review of emergency generator monthly test logs for generator #1 and generator #2 revealed the generators were exercised without a manual load transfer on; 1/28/19, 2/25/19, 10/4/19 ,11/1/19, 12/6/19 , 1/1/20, 2/3/20, 3/2/20, 4/2/20, 5/1/20, 7/1/20, 6/26/20, 8/3/20. During an interview on 9/10/20 at 12:54 PM, the Administrator stated the following: - He had no idea how to conduct or describe how to conduct a generator load test. -The Maintenance Director (no longer working at the facility) who conducted the monthly load tests and weekly audits of the emergency generators had a unique way of documenting the tests and audits. -The Director of Housekeeping/Laundry was conducting the monthly load tests. -The facility had no further documented evidence for monthly load tests and weekly audits for generator #1 and generator #2. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 99: 6.5.4, 6.4.1, 6.4.4.1.1.4(A)(B)(C) 2010 NFPA 110: 8.4, 8.4.1	K 918		
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920	1. The extension cord removed was removed from the autumn view south nursing station. The power strip was placed into a second wall outlet so power strips were not plugged in to power strips. 2. An initial audit was conducted by the director of maintenance or designee to ensure extension chords were not being used and power strips were not plugged in to other power strips. 3. The director of maintenance was re in serviced by the administrator on the regulation to ensure extension chords were	10/13/2020

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K 920	Continued From page 27 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 9/14/20, an extension cord and power strips were not properly maintained. Issues included, in-use extension cords and power strips that were plugged into other power strips were being used to supply power to various electrical devices. This affected one (Autumn View South) of five resident units and one of one Administrative Wing. The findings are: 1a. Observation on the Autumn View South Unit on 9/8/20 at 9:23 AM revealed a power strip that was plugged into an extension cord that was supplying power to a computer, a telephone and a shredding machine at the nurse's station. During the observation the Director of Housekeeping/Laundry stated he was not aware the extension cord was being used at the nurse's station. b. Observation on the Administrative Wing on	K 920	not being used and power strips were not plugged in to other power strips. 4. The director of maintenance or designee shall audit weekly for 4 weeks and monthly for 2 months, to ensure to ensure extension chords were not being used and power strips were not plugged in to other power strips. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action.	

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K 920	Continued From page 28 9/8/20 at 12:10 PM revealed a power strip plugged into a second power strip that was supplying power to a computer, two monitors and a cellular phone charger. During the observation the Director of Housekeeping/Laundry stated he was not aware the two power strips were plugged together. During an interview on 9/10/20 at 12:55 PM the Administrator stated, the facility had no documentation for auditing the facility for the use of power strips and extension cords. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 99: 10.2.4, 10.2.4.2, 10.2.4.2.1, 10.2.4.2.3, 10.2.3, 10.2.3.3.3, 10.2.3.6 2011 NFPA 70: 110.3(A)(1)(8), 400.8(1), 590.3(B)	K 920		
K 921 SS=E	NFPA 101 Electrical Equipment - Testing and Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are	K 921	1. A manual for scale 1 was produced and placed with the PCREE plant operation binder. A manual was obtained for the suction machine and nebulizer. An inspection log was created for the suction machine in the corridor near resident room #27 and placed in the PCREE binder. An inspection log was created for the nebulizer in resident room #26. An inventory list was created broken down by piece of equipment with corresponding inspection logs. Manuals were obtained for items inventoried. 2. An initial audit was conductor by the director of nurses, environment director, and therapy director to identify all defined PCREE equipment. 3. The director of maintenance was re in serviced by the administrator on the regulation to ensure PRCEE is inspected and tested and maintained per the manufacture's requirements and the need to keep documentation for the inspections	10/13/2020

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K 921	Continued From page 29 readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is not met as evidenced by: Based on observation, interview and record review during a Life Safety Code survey completed on 9/14/20, fixed and portable patient care related electrical equipment (PCREE) was not properly maintained. Issues included, the facility was not following its established policy and procedure for the inspection, testing, and maintenance of PCREE, the facility did not have documentation that all PCREE: was inspected and tested before being put into service and thereafter per the facility's policies and producers as well as manufacture's recommendations, manuals for PCREE were not readily available, the facility did not have documentation for the electrical equipment tests, repairs, and modifications of PCREE to demonstrate compliance in accordance with the facility's policies and procedures. The facility did not have documentation showing personnel responsible for the testing, maintenance, and use of electrical appliances received continuing training. This affected five (Autumn View North, Autumn View South, Canal View, Garden View and Orchard View Units) of five resident units. A review of the facility's Policy and Procedure,	K 921	and testing and maintenance of the PCREE. 4. The director of maintenance of designee shall review the PCREE inventoried list monthly, at identified times/frequency's – located on the respective inspection logs – identified times/frequencies from the respective items manual. The director of maintenance or designee shall review monthly, and add any items to the PCREE binder that are brought into the facility that is not currently in the PCREE binder. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action	

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K 921	Continued From page 30 Titled: Maintenance of Patient Care Related Electrical Equipment (PCREE) with an original date of issue 8/20017 revealed the following : "1. An inventory of all defined PCREE equipment will be conducted. 2. Assessed equipment includes items owned by the facility, supplied by a vendor, leased or rented. 3. Each piece of PCREE will be numbered and a coinciding log sheet per brand/type of equipment will be used to guide inspections/Preventative Maintenance (PM) 4. The list of PCREE to be inspected are the following: This list is not all inclusive it is meant to be a reference of equipment to be checked, Oxygen concentrators, breathing nebulizers, suction machines, IV delivery systems, feeding tube dispensers, glucometers, blood pressure monitors, scales, nurse call system, electric portable lifts, electric portable beds, pressure relieving mattresses, hydro therapy equipment, stationary bicycle, electric stim. machine, sit-in hair dryers. 5. PM will include testing measuring, adjusting and parts replacement that is performed specifically to prevent faults from occurring and ensure equipment is maintained in a satisfactory operating condition in accordance with the manufacture's guidelines. 6. Service Manuals of all PCREE will be maintained on site by the Maintenance Department via electronic and/or paper copy file. 7. Any new care related equipment brought in by the residents/families will be checked by the Maintenance Department prior to use in the facility and added to the PCREE log sheet." The findings are:	K 921		

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K 921	Continued From page 31 1a. Observation on the Autumn View North Unit on 9/10/20 at 8:45 AM revealed floor scale #1, serial number 305232, model number 6900, was stored in the corridor near Resident Room #225. Review of the facility's PCREE binder revealed the binder did not contain a manual for this floor scale. b. Observation on the Orchard View Unit on 9/10/20 at 9:20 AM revealed a suction machine, serial number 19990708013, stored on a cart in the corridor near Resident Room #27. Further observation at this time revealed no inspection logs were located on the cart. Review of the facility's PCREE binder revealed the binder contained no inspection logs or manual for the suction machine. c. Observation on the Orchard View Unit on 9/10/20 at 10:17 AM revealed a nebulizer, serial number 212V1809247832, in Resident Room #26. Review of the facility's PCREE binder revealed the binder contained no inspection logs or manual for the nebulizer. d. Review of the facility's PCREE binder revealed the binder did not contain: - An inventory of all defined PCREE equipment. - Documentation that each piece of PCREE was numbered and a coinciding log sheet per brand/type of equipment. - Preventative Maintenance documentation. - Service Manuals for all PCREE. - Documentation that new care related equipment brought in by the residents/families was checked by the Maintenance Department prior to use in the facility and added to the PCREE log sheet. During an interview on 9/10/20 1:04 PM the	K 921		

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K 921	Continued From page 32 Administrator stated, the facility had no documentation for the inspecting and testing of patient care related electrical equipment (PCREE) conducted by outside venders and the facility did not have any outside venders inspecting or testing the facility's patient care related electrical equipment. The Administrator further stated the facility had no other PCREE documentation or information than what was previously provided in the facility's PRCEE binder. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 99: 1.3.1, 10.3, 10.3.5.4, 10.3.6, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.3.1, 10.5.6, 10.5.6.1.1, 10.5.6.1.3, 10.5.8, 10.5.8.1, 10.5.8.1.1	K 921		
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required	K 923	1. The oxygen cylinder in resident room # 16 was properly secured. 2. An initial audit was conducted by the director of maintenance or designee to ensure all oxygen cylinders were properly secured. 3. All employees were re in serviced by the administrator and respective department heads, on the regulation for properly securing an oxygen cylinder. 4. The director of maintenance shall audit proper oxygen storage weekly for 4 weeks and monthly for 2 months. 5. Audits shall be reviewed at the QA meeting and confirmed to ensure compliance. The Administrator shall be responsible for the implementation and evaluation of this corrective action	10/09/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING 01 - 1960 BLDG. B. WING	09/14/2020

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

(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) COMPLETE DATE
K 923	Continued From page 33 to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey completed on 9/14/20, an oxygen cylinder was not properly maintained. Issues included, an oxygen cylinder was stored free-standing and unsecured. This affected one (Orchard View) of five resident units. The finding is: Observation on the Orchard View Unit on 9/8/20 at 11:12 AM revealed an E-size oxygen cylinder was stored free-standing and unsecured in resdient room 16. Further observation revealed there were no residents or staff inside the room. During the observation, the Director of Housekeeping/Laundry stated that the oxygen cylinder needed to be properly secured. During an interview on 9/10/20 at 12:50 PM, the Administrator stated there was no documentation for auditing proper oxygen	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING 01 - 1960 BLDG. B. WING _____	09/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 34 cylinder storage throughout the facility. 10 NYCRR 415.29(a)(2), 711.2(a)(1) 2012 NFPA 2012: 19.3.2.4 2012 NFPA 99: 11.3.3.2, 11.6.2, 11.6.2.3(11)	K 923		

EXHIBIT 49

LEASE AGREEMENT

LEASE AGREEMENT (the "Lease"), by and between Telegraph Realty LLC ("Lessor") and Comprehensive at Orleans LLC ("Lessee").

WITNESSETH

WHEREAS, Lessor owns a 120-bed Skilled Nursing Facility currently known as The Villages of Orleans Health and Rehabilitation Center which is located at 14012 Route 31 West, Albion, New York (the "Facility"); and

WHEREAS, Lessor desires to lease to Lessee, and Lessee desires to lease from Lessor, the Facility and the other real and personal property, equipment and interests described in this Lease on the terms and conditions described below;

NOW, THEREFORE, in consideration of the mutual promises, covenants and agreements contained in this Lease, and other good valuable consideration, the receipt and sufficiency of which are acknowledged and confessed, the parties, intending to be legally bound, agree as follows:

ARTICLE I
LEASE

1.1 **Leased Premises.** Lessor hereby leases, rents and lets unto Lessee, and Lessee hereby leases, rents and hires from Lessor, for the Lease Term (as hereinafter defined) and subject to all the covenants and conditions hereinafter stated, all rights, title and interest of Lessor in and to the following (collectively, "the Leased Premises"):

1.1.1 All of the real property upon which the Facility is located (the "Real Property"), including without limitation the building and fixtures (the "Buildings") located thereon, together with all tenements, hereditaments, rights, privileges, interests, easements and appurtenances now or hereafter belonging or in any way pertaining to the Real Property, Buildings and/or the Facility. The Real Property is more particularly described on Exhibit 1.1.1.

1.1.2 All equipment, furniture, inventory (to which Lessor has lawful title, specifically including, but not limited to, office supplies, other supplies and foodstuffs (hereinafter the "Inventory"), appliances, tools, instruments, and other tangible personal property owned by Lessor as of the date of this Lease, and located on the Real Property (the "Personal Property").

1.2 **Lease Term**. The term of this Lease shall commence as the closing date of pursuant to the Facility Transition Agreement between the County of Orleans and Lessee (the "Commencement Date"), and expire on the 10 year anniversary of the Commencement Date, unless sooner terminated as hereinafter provided (the "Lease Term"). Notwithstanding anything in this Lease to the contrary, the commencement of

the Lease is contingent upon Lessee's receiving all necessary authorizations and consents which, in the sole discretion and option of Lessee, are necessary or desirable for Lessee to obtain in order to operate the Facility. Such authorizations include, but are not limited to (a) any necessary or required governmental or regulatory licenses, certifications or other consents and (b) any necessary or required consents or authorizations from any mortgages or lenders of the Facility or of the Lessor. The Lease is also conditioned upon the Lessor obtaining title and possession of the Leased Premises.

ARTICLE II
LEASE PAYMENTS AND OTHER FINANCIAL CONSIDERATIONS

2.1 **Rent**. During the Lease Term, Lessee covenants and agrees to pay, as lease payments hereunder, the monthly Debt Service as set forth on Exhibit A plus Fifty Thousand ($50,000) Dollars per month (the "Rent'). The Rent shall be due and payable on or before the first day of each month.

In addition to the foregoing, Lessee shall pay all taxes due of any sort relating to the Leased Premises including but not limited to all real estate and personal property tax. It shall likewise pay for all insurance and for all repairs to the Leased Premises as is reasonably required by Lessor to maintain the Leased Premises in a condition which is substantially the same as the condition thereof on the Commencement Date.

It is understood and agreed that Lessor shall be obligated to make any mortgage payments relating to the Leased Premises as said payments become due. In the event that Lessor fails to make such mortgage payments, Lessee may make the mortgage payments and Lessee shall be entitled to deduct from the Rent the amount of such mortgage payments actually paid by Lessee.

ARTICLE III
USE OF LEASED PREMISES/COMPLIANCE WITH LAW

3.1 **Use of Premises**. During the Lease Term, Lessee shall use the Leased Premises for the sole and exclusive purpose of operating a nursing home, which shall be continuously open and operating. The Lessee shall operate the Facility in accordance with standards at least equal to those prescribed by all governmental bodies having jurisdiction over (i) the Facility and/or (ii) its eligibility to receive reimbursement or other payment from public funds with respect to services rendered to patients eligible to benefit from any public program providing for such reimbursement or other payment and shall at all times operate the Facility in a manner consistent with the zoning laws then in effect and the certificate of occupancy.

3.2 **Compliance with the Law**. Lessee shall maintain and conduct Lessee's business on the Leased Premises in a lawful manner and shall timely and fully comply with all federal, state and local laws, statutes and ordinances and all regulations, orders and directives of appropriate governmental and accrediting agencies, as such laws,

statutes, ordinances, regulations, orders and directives now existing or that may hereafter be enacted, and, at Lessee's sole cost and expense, make any repairs, changes or modifications in or to the Leased Premises required by any of the foregoing.

3.3 **Waste; Nuisance**. Lessee shall not perform or fail to perform any acts or carry on or permit to exist any practices that may injure or damage the Leased Premises in any respect or that may constitute a public or private nuisance or menace to the owners or occupants of adjacent property, or that may violate the provisions of any required insurance on the Leased Premises or that may diminish the coverage under such insurance or render such insurance void. Lessee shall not commit or suffer to exist any waste upon the Leased Premises.

3.4 **Liens.** Lessee shall not permit any Liens upon the Leased Premises.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF LESSOR

Lessor hereby warrants and represents to Lessee, as of the date of this Lease, that:

4.1 **Authority**. Lessor has full power and authority to execute and to deliver this Lease and all related documents, and to carry out the transaction contemplated herein. This Lease is valid, binding and enforceable against Lessor in accordance with its terms. The execution of this Lease and the consummation of the transaction contemplated herein do not result in a breach of the terms and conditions of, nor constitute a default under, nor violation of any law, regulation, court order, mortgage, note, bond, indenture, agreement, license or other instrument or obligation to which Lessor is now a party or by which Lessor or any of the assets of Lessor may be bound or affected.

4.2 **Title**. Lessor has good and insurable fee simple title to the real property identified and described on Exhibit 1.1.1 hereto, subject only to the easements, reservations and encumbrances of record, those which an accurate survey would disclose or which are identified in the Title Report or schedule thereto ("Permitted Exceptions"), and has good and insurable title to the personal property to be leased to Lessee under the term of this Lease. Lessor warrants that so long as Lessee is not in default hereunder, Lessee shall have quiet enjoyment of the Leased Premises.

4.3 **The Facility**. The Facility is a Residential Health Care Facility ("RHCF") with a total of 120 operational and licensed beds and the personal property used to operate the RHCF at full capacity.

4.4 **Licensure**. The Facility is a duly and properly licensed RHCF with 120 beds. As of the Commencement Date there shall be no action pending or, to the best knowledge of Lessor, recommended by the appropriate state or federal agency having jurisdiction thereof, to terminate the participation with any agency or program, nor shall

there be any decision not to renew any provider agreements related to the RHCF, or any actions of any other type which would have an adverse and material effect on the Facility, its operations or business except as disclosed to Lessee.

4.5 **Intentionally Deleted.**

4.6 **Intentionally Deleted**.

4.7 **Compliance with Law**. Lessor is not aware of any notice of any claim, requirement of demand of any licensing or certifying agency supervising or having authority over the Facility or otherwise to rework or redesign it or to provide additional furniture, fixtures, equipment or inventory so as to conform to or comply with any existing law, code or standard which has not been fully satisfied prior to the date hereof.

4.8 **Litigation**. To the best of Lessor's knowledge, there is no litigation, investigation or other proceeding pending or threatened against Lessor, its properties or business, which involves or relates to the Premises or the Facility, and the transaction contemplated herein has not been challenged by any governmental agency or any other person.

ARTICLE V
REPRESENTATIONS AND WARRANTIES OF LESSEE

Lessee hereby warrants and represents to Lessor, as of the date of this Lease and continuing up to and throughout the Lease Term, that:

5.1 **Status of Lessee**. Lessee is a limited liability company duly organized and validly existing under the laws of the State of New York, and is qualified to do business in the State of New York.

5.2 **Authority**. Lessee has full power and authority to execute and to deliver this Lease and all related documents, and to carry out the transactions contemplated herein. This Lease is valid, binding and enforceable as against Lessee in accordance with its terms. The execution of this Lease and the consummation of the transaction contemplated herein do not result in a breach of the terms and conditions nor constitute default under or violate Lessee's Articles of Organization or any law, regulations, Court order, mortgage, note, bond, indenture, agreement, license or other instrument or obligation to which Lessee is a party or by which Lessee or any of the assets of Lessee may be bound or affected.

5.3 **Litigation**. To the best of Lessee's knowledge there is no litigation, investigation or other proceeding pending or threatened against or in relation to Lessee, its properties or business which is material to this Lease, nor does Lessee know or have reasonable grounds to know of any business for any such action.

5.4 **Necessary Action**. Lessee has taken all action necessary to enter into this Lease and to carry out the terms of this Lease.

5.5 **Taxes**. Lessee has filed all tax returns (federal, state and local) required to be filed and paid all taxes shown thereon to be due, including interest and penalties, other than such taxes that Lessee is contesting in good faith by appropriate legal proceedings and proper reserves have been established on the books of the Lessee.

5.6 **Liens**. There are no liens, charges or encumbrances upon or with respect to any of the properties of Lessee or right to receive revenues of Lessee other than Permitted Liens.

5.7 **Conflicts**. Lessee is not a party to any indenture, loan or credit agreement or any lease or other agreement or instrument (including company charters or other organizational documents) which is likely to have a material adverse effect on the ability of Lessee to perform its obligations under the Lease or which would restrict or otherwise limit the incurring of the debt arising under this Lease.

5.8 **Compliance with Laws; Licensure.** Lessee is in material compliance with all laws, orders, regulations and ordinances of all federal, foreign, state and local governmental authorities binding upon or materially affecting the business, operation or assets of Lessee or has a plan of correction in place accepted by the State of New York to promptly cure such violations. Lessee has not (i) had a civil monetary penalty assessed against it under the Social Security Act ("SSA") § 1128(a), (ii) been excluded from participation under the Medicare program or under a State health care program as defined in SSA §1128 (h) ("State Health Care Program"), or (iii) been convicted (as that term is defined in 42 C.F.R. §1001.2) of any of the following categories of offenses as described in SSA §1127(a) and (b) (1), (2), (3): (A) criminal offenses relating to the delivery of an item of service under Medicare or any State Health Care Program; (B) criminal offenses under federal or state law relating to patient neglect or abuse in connection with the delivery of a health care item or service; (C) criminal offenses under federal or state law relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any federal, state or local government agency; (D) federal or state laws relating to the interference with or obstruction of any investigations into any criminal offense described in (A) through (C) above; or (E) criminal offenses under federal or state law relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance. Lessee holds all necessary licenses, permits and certifications required by any applicable governmental authority to operate and maintain a nursing home with 120 skilled beds, which is qualified to participate in both Medicare and Medicaid reimbursement programs without limitation, suspension or revocation of privileges. Lessee has materially complied with all applicable requirements of the United States of America, the State of New York and all applicable local governments, and of its agencies and instrumentalities, to manage the Facility as it is to be operated. Lessee shall

file all cost reports required to be filed with respect to the Facility's nursing home operations and the same shall be accurate in all material respects and in compliance with all applicable governmental rules and regulations. Lessee shall be in substantial compliance with and maintain provider agreements under Title XVII and XIX of the Social Security Act for reimbursement for long term nursing care and is qualified to participate in both Medicare and Medicaid reimbursement programs.

5.9 **Solvency.** Lessee has capital sufficient to carry on its business and transactions and all businesses and transactions in which it is about to engage and is solvent and able to pay its debts as they mature. No transfer of property is being made and no debt is being incurred in connection with the transactions contemplated by this Agreement with the intent to hinder, delay or defraud either present or future creditors of Lessee.

5.10 **Debt**. As of the date of this Agreement, Lessee does not have any debt except for loans made by Lessor to Lessee.

5.11 **Accuracy of Information**. To the best of Lessee's knowledge after a due and diligent investigation, all factual information heretofore or contemporaneously furnished by or on behalf of Lessee to Lessor for the purposes of satisfying the provisions of or in connection with this Agreement or any transaction contemplated hereby is, and all other factual information (taken as a whole) hereafter furnished by or on behalf of Lessee to Lessor will be, to the best of Lessee's knowledge after a due and diligent investigation, true and accurate in every material respect on the date as of which such information is dated or certified, and Lessee has not omitted and will not omit any material fact necessary to prevent such information from being false or misleading. Lessee has disclosed to Lessor, in writing, all facts which Lessee has knowledge of and which Lessee believes is more likely than not to materially and adversely affect the business, credit, operations or financial condition of Lessee or which Lessee believes is more likely than not to materially and adversely affect any material portion of Lessee's property, or Lessee's ability to perform its obligations under the Lease.

ARTICLE VI
MAINTENANCE AND REPAIR

6.1 **Maintenance and Repair**. Throughout the Lease Term, Lessee, at Lessee's sole cost and expense, shall keep and maintain the Leased Premises and all parts thereof in good working order and condition, ordinary wear and tear excepted, including but not limited to, the maintenance, repair and replacement, if necessary, of the roof, foundation, all structural components, the heating, ventilation and air conditioning system of the Facility and all plumbing, electrical and equipment systems of the Facility and the grounds, driveways, walkways, paving and parking lots of the Leased Premises. Lessee acknowledges that Lessor shall have no obligations concerning repairs to or maintenance of the Leased Premises.

ARTICLE VII
EQUIPMENT

7.1 **Lessor's Equipment**. All equipment, furniture and furnishings on hand as of the Commencement Date and which are not tagged or marked by Lessee as Lessee's equipment shall constitute a part of the Leased Premises and shall be and remain the personal property of Lessor ("Lessor's Equipment").

7.2 **Lessee's Equipment**. All equipment, fixtures, and furnishings acquired by Lessee and not constituting Lessor's Equipment shall be and remain the personal property of Lessee ("Lessee's Equipment") and shall be tagged or marked by Lessee as such.

7.3 **Disposition of Obsolete Equipment**. Lessor and Lessee recognize that portions of Lessor's Equipment may become inadequate, obsolete, worn out, unsuitable, undesirable or unnecessary in the operation of the Leased Premises. In any instance in which Lessee in its sole discretion determines that any items of Lessor's Equipment has become inadequate, obsolete, worn out, unsuitable, undesirable or unnecessary in the operation of the Leased Premises, Lessee may remove such items of Lessor's Equipment from the Leased Premises, and on behalf of Lessor sell, trade-in, exchange or otherwise dispose of same without any responsibility or accountability to Lessor thereof; provided, however, that Lessee shall substitute and install in the Leased Premises other equipment having equal or greater utility (but not necessarily the same function) in the operation of the Leased Premises, and provided further that such removal and substitution shall not impair the operations of the Leased Premises. All such substitute equipment shall constitute Lessor's Equipment and shall be held by Lessee on the same terms and conditions as items originally comprising Lessor's Equipment. Lessee shall execute and deliver to the Lessor such documents as may from time to time be requested to confirm the title of the Lessor to any items of Lessor's Equipment. Lessee will not remove or permit the removal of any Lessor's Equipment from the Leased Premises except in accordance with the provisions in this Section.

ARTICLE VIII
TAXES AND UTILITIES

8.1 **Taxes**. From and after the Commencement Date, Lessee shall be responsible for and shall pay prior to delinquency any and all taxes, assessments, charges, and all other amounts demanded from any governmental and/or quasi-governmental agency for or relating to the Leased Premises including, but not limited to, ad valorem taxes assessed against the Leased Premises, and any and all federal, state or local taxes incurred or assessed in connection with Lessee's operation of the Leased Premises, including, without limitation, federal and state income taxes, franchise taxes, FICA, FUTA and other unemployment taxes. It shall not be a defense that such tax, assessment

or charge was not in existence or contemplated at the time of the execution of this Agreement.

8.2 **Utilities**. Lessee shall be solely responsible for and shall pay all charges for utilities in respect of the Leased Premises, including, without limitation, charges for water, gas, electricity, sewer service, refuse disposal, telephone service and similar services incurred in connection with the operation of the Leased Premises during the Lease Term.

ARTICLE IX
INSURANCE

9.1 **General Requirements**. Lessee, at the sole cost and expenses of Lessee, covenants to obtain and maintain throughout the Lease Term a commercial property policy covering Building, Contents and Business Income interruption. Such policy shall, at Lessor's option, be payable to the Lessee and Lessor and any mortgagee of Lessor, as their interest may appear. Lessee shall furnish to Lessor a certificate showing that such policy is in effect and premiums therefor have been paid. Upon written notice of Lessor, Lessee shall also be required to obtain any insurance which is commercially reasonable at Lessee's expense for the benefit of Lessor and/or its lenders.

9.2 **Cancellation/Certification**. Certificates of insurance evidencing such coverage shall be delivered to Lessor prior to the Commencement Date and annually thereafter prior to expiration of the then-current policy terms.

ARTICLE X
DAMAGE, DESTRUCTION AND CONDEMNATION

10.1 **Damage or Destruction**. Should the building upon the Leased Premises be totally or partially destroyed by fire or other cause, the damage shall be repaired and the building restored with the proceeds of the insurance provided for in Article IX of the Lease. Should the building be damaged by any cause whatsoever, so that rebuilding or repairs are not completed within six (6) months of the occurrence of such damage, this Lease may be terminated at the option of the Lessee. Lessee shall be allowed an equitable abatement of the rent during such time as it is unable to enjoy the use of the whole or part of the Leased Premises.

10.2 **Condemnation**. In the event that all or any part of the Leased Premises shall be taken or damaged by the exercise of the power of eminent domain, then (whether or not this Lease shall terminate by operation of law upon such exercise of the power of eminent domain) the respective interest of the Lessor and Lessee in and to the Leased Premises by reason of such exercise of power and eminent domain shall be separately determined and computed by the Court having jurisdiction and separate awards and judgments with respect of such damage to the Lessor and Lessee, respectively, and to each of such respective interest, shall be made and entered. The Lessor shall receive and

retain the full amount of such damages to be determined whether or not such amount is in its favor or in favor of the Lessee. In the event the Leased Premises is so substantially and permanently taken by the power of eminent domain as to make the Leased Premises in the reasonable and good faith opinion of the Lessee unsuitable for continuing the operation of the Facility, then this Lease may be terminated by the Lessee, as of the effective date of the taking, by notice given by Lessee to Lessor. Any such termination shall be without prejudice to any claim of Lessee against the condemning authority for damages resulting to Lessee from such condemnation. In the event the Leased Premises shall be partially and permanently taken by the power of eminent domain but in the reasonable and good faith opinion of Lessee, Lessor and any of its lenders, if such consent is required by any loan documents then in effect, the uncondemned portion of the Leased Premises is suitable for continuing the operation of the Facility, then this Lease shall not terminate and Lessor shall repair the Leased Premises, with an equitable abatement of the monthly rent commensurate with a proportionate percentage reduction in income to Lessee as a result of the taking.

ARTICLE XI
SURRENDER OF POSSESSION

11.1 **Surrender**. Upon the expiration or termination of the Lease Term, howsoever effected, Lessee shall forthwith surrender the Leased Premises to Lessor, free and clear of all claims, liens, security interests and other encumbrances (except Permitted Encumbrances and other encumbrances approved in writing by Lessor during the Lease Term) and in as good working order and condition as on the Commencement Date, ordinary wear and tear excepted. Lessor's Equipment and all inventory acquired by Lessee during the Lease Term and on hand as of the date of expiration or termination shall also be surrendered to Lessor and all equipment and inventory surrendered shall have an aggregate functional capability at least equal to the aggregate functional capability of the equipment and inventory existing at the Facility as of the Commencement Date, Lessee may remove Lessee's Equipment from the Leased Premises upon the expiration or termination of the Lease Term; provided, however, that Lessee shall be responsible for and shall immediately repair any damage to the Leased Premises caused by the removal of Lessee's Equipment.

ARTICLE XII
DEFAULT AND LEASE TERMINATION

12.1 **Events of Default of Lessee**. Each of the following acts, omissions or occurrences shall constitute an "Event of Default of Lessee" hereunder:

A. Failure by Lessee to pay or cause to be paid, within ten (10) business days of the date required, rent specified to be paid under Section 2.1 hereof or any other monetary amount due to Lessor;

B. The vacating of the Leased Premises by Lessee;

C. Failure of Lessee to observe and perform any covenant, condition or agreement of Lessee under this Lease, other than a breach addressed in Section 12.1(A) above, within ten days (10) after the date Lessee receives written notice of such failure of performance, or, with respect to failures of performance not susceptible of cure within ten (10) days upon approval in writing by the Lessor, the failure of Lessee to thereafter diligently prosecute same to completion and/or cure the same within sixty (60) days;

D. Lessee shall make a transfer in fraud to creditors or shall make an assignment for the benefit of creditors;

E. Lessee shall file a petition under any section or chapter of the United States Bankruptcy Code, as amended, or under any similar law or statue of the United States or any state thereof, or Lessee shall be adjudged bankrupt or insolvent in proceeding filed against Lessee thereunder;

F. The filing or execution or occurrence (or contemplation thereof) of any of following: (i) the appointment of a trustee or receiver to take possession of substantially all of Lessee's assets or of Lessee's leasehold estate in the Leased Premises; or (ii) the judicial seizure of substantially all of Lessee's assets or Lessee's leasehold estate in the Leased Premises; or

G. Any representation or warranty of Lessee is breached or is false or misleading in any material respect when made or which becomes false during the pendency of this Lease.

12.2 **Remedies of Lessor**. Upon the occurrence and continuance of any Events of Default of Lessee specified in the foregoing Section 12.1, Lessor shall have the option to pursue any one or a combination of the following remedies without any notice to or demand upon Lessee whatsoever provided however Lessor must notify the Commissioner of its intent to exercise its remedies hereunder and remove the licensed Operator from the premises in accordance with 10 NYCRR§ 401.3:

A. Terminate this Lease, in which event Lessee shall immediately notify the Commissioner of the Department of Health (the "Commissioner") of its intention to surrender its operating certificate pursuant to 10 NYCRR §401.3 ninety (90) days prior to the surrender of the Leased Premises to Lessor, and if Lessee fails to so notify the Commissioner, Lessor shall notify the Commissioner of its intention to terminate this Lease and take possession of the Leased Premises. If Lessee fails to surrender the Leased Premises after receipt of the Commissioner's written approval of the Lessee's surrender of its operating certificate,

Lessor may, without prejudice to any other remedy which Lessor may have, expel or remove Lessee and any other person who may be occupying the Leased Premises, or any part thereof, at Lessee's expense. In such event Lessor may, in addition to the foregoing, seek such other damages and remedies as are available at law or in equity for Lessee's breach of this Lease.

B. Enter upon and take possession of the Leased Premises and expel or remove Lessee and any other person who may be occupying Leased Premises, at Lessee's expense, or any part thereof, at Lessee's expense, without terminating this Lease, and exercise reasonable efforts to re-let the Leased Premises, as Lessee's agent, at the highest rent then obtainable and receive the rent therefor; and Lessee covenants and agrees to pay Lessor on demand any cost or expense incurred by Lessor in connection with re-letting the Leased Premises and any deficiency in Rent that may arise by reason of such re-letting. In no event shall Lessee be entitled to any profit made from any re-let or be relieved of any obligation to make rent payments in the event the party re-letting fails to do so.

C. Enter upon the Leased Premises and, at Lessee's expense, take such actions as may be required of Lessee to cure the complained of default; and Lessee covenants and agrees to reimburse Lessor on demand for any expense, direct or indirect, which Lessor may incur in thus effecting compliance with Lessee's obligations under this Lease.

D. Pursuit of any of the foregoing remedies shall not preclude pursuit of any other foregoing remedies or of the other remedies herein provided or any other remedies provided at law or in equity, nor shall pursuit of any remedy herein provided constitute a forfeiture or waiver of any Rent or other amounts due to Lessor hereunder or of any damages accruing to Lessor by reason of the violation of any of the terms, provisions or covenants herein contained. No waiver by Lessor of any violation or breach of any of the terms, provisions or covenants herein contained shall be deemed or construed to constitute a waiver of any other violation or breach of any of the terms, provisions or covenants herein contained. Forbearance by Lessor to enforce one or more of the remedies herein provided upon an Event of Default of Lessee shall not be deemed or construed to constitute a waiver of such default.

E. To the extent any amounts due to Lessor under the terms of this Lease, whether as a result of an Event of Default or otherwise, are not timely paid, such amounts shall bear interest at the rate of

eighteen percent (18%) per annum from the date such amounts were due until paid to Lessor.

12.3 **Events of Default of Lessor**. Each of the following acts, omissions or occurrences shall constitute an "Event of Default of Lessor" hereunder:

A. Failure of Lessor to observe and perform any material covenant, condition or agreement of Lessor under this Lease within ten days (10) after the date Lessor receives written notice of such failure of performance, or, with respect to failure of performance not susceptible of cure within ten (10) days upon approval in writing by the Lessee, the failure of Lessor to commence a cure within said ten (10) day period and to thereafter diligently prosecute same to completion;

B. Lessor shall make a transfer in fraud to creditors or shall make an assignment for the benefit of creditors;

C. Lessor shall file a petition under any section or chapter of the United States Bankruptcy Code, as amended, or under any similar law or statute of the United States or any state thereof or Lessor shall be adjudged bankrupt or insolvent in proceedings filed against Lessor hereunder; or

D. The filing or execution or occurrence (or contemplation thereof) of any of the following: (i) the appointment of a trustee or receiver to take possession of substantially all of Lessor's assets or of Lessor's leasehold estate in the Leased Premises; or (ii) the judicial seizure of substantially all of Lessor's assets or of Lessor's leasehold estate in the Leased Premises.

12.4 **Remedies of Lessee.** Upon the occurrence and continuance of any of the Events of Default of Lessor specified in the foregoing Section 12.3, Lessee shall have the option to pursue any one or combination of the following remedies without any notice to or demand upon Lessor whatsoever:

A. Terminate this Lease, in which event Lessee shall surrender the Leased Premises to Lessor upon notice to Lessor without further remedy.

B. Take such actions as may be required of Lessor from time to time to cure the complained of default; and Lessor covenants and agrees to reimburse Lessee on demand for any expenses, direct or indirect, which Lessee may incur in thus effecting compliance with Lessor's obligations under this Lease. Lessee may not deduct amounts due hereunder from payments due to Lessor.

Pursuit of any foregoing remedies shall not preclude pursuit of any of the other foregoing remedies or of the other remedies herein provided or any other remedies provided at law or in equity. No waiver by Lessee of any violation or breach of any of the terms, provisions or covenants herein contained shall be deemed or construed to constitute a waiver of any other violation or breach of any of the terms, provisions or covenants herein contained. Forbearance by Lessee to enforce one or more of the remedies herein provided upon an Event of Default of Lessor shall not be deemed or construed to constitute a waiver of such default. To the extent any amounts due to Lessee under the terms of this Lease, whether as a result of an Event of Default of Lessor or otherwise, are not timely paid, such amounts shall bear interest at the rate of seven percent (7%) per annum from the date such amounts were due until paid to Lessee.

12.5 **Department of Health Notification.** Notwithstanding anything to the contrary contained herein:

> The Lessor acknowledges that its rights of reentry into the Leased Premises set forth in this Lease do not confer on it the authority to operate a hospital as defined in article 28 of the Public Health law on the Leased Premises and agrees that it will give the New York State Department of Health, Tower Building, Empire State Plaza, Albany, N.Y. 12237, notification by certified mail of its intent to reenter the Leases Premises or to initiate dispossess proceedings or that the Lease is due to expire, at least 30 days prior to the date on which the Lessor intends to exercise a right of reentry or to initiate such proceedings or at least 60 days before the expiration of the Lease. Upon receipt of notice from the Lessor of its intent to exercise its right of reentry or upon the service of process in dispossess proceedings and 60 days prior to the expiration of the Lease, the Lessee shall immediately notify by certified mail the New York State Department of Health, Tower Building, Empire State Plaza, Albany, NY 12237, of the receipt of such notice or service of such process or that the Lease is about to expire.

ARTICLE XIII
PROHIBITION AGAINST LIENS

13.1 **Prohibition Against Liens.** Lessee covenants that it will not create any lien, encumbrance or charge upon the Leased Premises, Rent payable hereunder, or any part of either of the foregoing, and that it will satisfy or cause to be discharged, within thirty (30) days after the same shall accrue, all lawful claims and demands for labor, materials, supplies or other items which, if not satisfied, might by law become a lien upon Lessee's leasehold estate in the Leased Premises or Rent payable hereunder or any part of either. If any such lien shall be filed against Lessee's leasehold estate in the Leased Premises, or asserted against Rent or any amounts due hereunder, by reason of work, labor or services or asserted against Rent, by or to the Facility at the request of the Lessor

with the permission of Lessee, Lessee shall, within fifteen (15) days after notice is received of the filing thereof or the assertion thereof against the Lessee's leasehold estate in the Leased Premises or Rent, by contest, payment, deposit, bond, order of Court or otherwise. Nothing in this Section 13.1 shall require the Lessee with an opinion of independent counsel that failure to satisfy or discharge such charge, claim or demand in such manner that the interest of Lessor, in the opinion of independent counsel, is not jeopardized. In no event and under no circumstances shall Lessee cause or suffer to exist any lien against or encumbrance upon Lessor's interest in the Leased Premises.

13.2 **Permitted Liens**. Notwithstanding any provision of this Lease to the contrary but without limiting Lessee's obligation to timely pay Rent and other amounts due and payable by Lessee hereunder, Lessee may create or permit to be created the following liens or encumbrances with respect to Lessee's leasehold interest in the Leased Premises ("Permitted Liens"):

A. Liens granted in connection with any improvements, expansion, extension, additions or modifications of the Facility or any real property adjacent thereto.

B. Any liens, charges, encumbrances and restrictions which may be created or exist by reason of this Lease or loan from Lessor.

C. Liens, charges and encumbrances for taxes or assessments or other government charges or levies not then delinquent.

ARTICLE XIV
LIABILITIES AND INDEMNIFICATION

14.1 **Liabilities**. It being understood that Lessor is simultaneously purchasing and leasing the Leased Premises, Lessee shall assume any and all obligations or liabilities of the Lessor, the Facility or any obligation or liability relating to the Lessor or to the Facility, of any nature whatsoever (whether express or implied, fixed or contingent, liquidated or unliquidated, known or unknown, accrued or unaccrued, due or to become due), relating to any period prior to the termination or expiration of this Lease except such obligation or liability caused by Lessor's gross negligence or intentional wrongdoing.

14.2 **Indemnification**. Lessee agrees to and does hereby indemnify and hold the Lessor, its officers, directors, agents, employees and lenders harmless from and against any claims, demands, causes of action, liability, loss, damage, deficiency, cost or expense (including, without limitation, reasonable attorney's fees and associated costs and expenses) resulting from (i) the acts or omissions of Lessee and Lessee's employees, agents, independent contractors, guests, invitees or any other persons or thing in respect of the Facility or caused in whole or in part by breach of this Agreement, (ii) any

misrepresentation, breach of warranty or non-fulfillment of any agreement, representation, warranty or condition by or on the part of Lessee under this Lease, or (iii) any liability asserted against Lessor, its officers, directors, agents, employees and Lenders in any way relating to the Lessee or to the Facility except those liabilities specifically assumed herein by Lessor.

ARTICLE XV
INSPECTION

15.1 **Inspections**. Lessor and Lessor's agents, insurers, lenders and/or representatives shall have the right to enter and inspect the Leased Premises during normal business hours.

ARTICLE XVI
ACCESS TO RECORDS AND REPORTING REQUIREMENTS OF LESSEE

16.1 **Access**. The Lessor shall have access to records of the Lessee, which are determined by mutual agreement of the parties to be reasonably necessary for the Lessor to be able to ensure that the Lessee is complying with the terms and conditions set forth herein. Notwithstanding anything provided herein to the contrary, Lessor shall not have access to review patient medical records in possession of the Lessee without the specific consent of such patients and/or without complying strictly with all local, State, and Federal laws, rules, and regulations relating to the protection of confidential patient records.

16.2 **Reporting Requirements of Lessee**. Lessee shall keep true books of record and account in which full, true and correct entries in accordance with GAAP consistently applied will be made of all dealings or transactions in relation to its business and activities, and an authorized member of Lessee shall furnish to Lessor:

(i) as soon as possible and in any event within ten (10) days after the occurrence of an Event of Default or any event which, with the giving of notice, lapse of time, or both, would constitute an Event of Default, and if requested by Lessor, a statement of an authorized member of Lessee setting forth details of such Event of Default or event and the action which Lessee has taken or proposes to take to cure the same;

(ii) as soon as reasonably available and in any event within seventy-five (75) days after the end of each calendar quarter, internally-prepared financial statements of Lessee, including a Balance Sheet and the related Income Statement as of the end of such quarter and for the portion of the fiscal year ended at the end of such quarter, setting forth in each case in comparative form the figures for the corresponding quarter and the corresponding portion of the previous fiscal year, all in reasonable detail and certified (subject to normal year-end adjustments) as to fairness of presentation, in accordance with GAAP, by Lessee's managing

member;

(iii) as soon as reasonably available and in any event within one hundred twenty (120) days after the close of each fiscal year, a combined and combining Balance Sheet and the related Income Statement as of the end of such fiscal year, fairly and accurately presenting the financial condition of Lessee at such date and the results of operations of Lessee for such fiscal year and setting forth in each case in comparative form the corresponding figures for the corresponding period of the preceding fiscal year, all in reasonable detail, prepared in accordance with GAAP consistently applied, compiled and reviewed, in each case, by an independent certified public accountant acceptable to Lessor and Lessee. For the purposes of this provision, Jay Bakst, CPA, is deemed to be acceptable to Lessor and Lessee. Lessor may, but is not required to, hire an independent certified public accountant of its choosing, at Lessee's own expense to verify the foregoing;

(iv) at Lessor's request, a schedule showing the accounts receivable agings delivered to Lessor within thirty (30) days after the end of each month;

(v) promptly upon receipt and, in any event, within thirty (30) days after receipt thereof, copies of all interim and supplemental financial reports submitted to Lessee by independent certified public accountants in connection with any interim review of the books and records of Lessee made by such accountants;

(vi) as soon as available and in any event within fifteen (15) days after filing, copies of all cost reports filed with Medicaid or any other applicable state or federal agency;

(vii) within fifteen (15) days of Lessor's request, a copy of the most recent annual or biannual certification survey report and any statement of deficiencies with plans of correction attached thereto;

(viii) immediately after notice to Lessee of the commencement thereof, notice, in writing, of any action, suit, arbitration or other proceeding instituted, commenced or threatened against or affecting the Lessee with an amount in controversy in excess of $100,000;

(ix) as soon as available and in any event within fifteen days of filing, Lessee's federal, state and local tax returns, if and as applicable, as soon as said returns are completed in the form said returns will be filed with the Internal Revenue Service and any state or local department of revenue or taxing authority; and

(x) such other information respecting the condition or operations, financial or otherwise, of Lessee as Lessor may from time to time reasonably request, including, without limitation, annual public aid rate updates, monthly accounts receivable aging reports, cost reports, annual survey reports and budget and cash flow projections.

ARTICLE XVII
MISCELLANEOUS PROVISIONS

17.1 **Additional Assurances.** The provisions of this Lease shall be self-operative and shall not require further agreement by the parties except as may be provided herein to the contrary; provided, however, at the request of either party, the other party shall execute such additional instruments and take such additional acts as may reasonably be necessary to effectuate this Lease,

17.2 **Legal Fees and Costs.** In the event either Lessor or Lessee institute any proceedings to enforce or interpret any provision of this Lease, the prevailing party will be entitled to recover its legal expenses, including, without limitation, reasonable attorney's fees, costs, and necessary disbursements, in addition to any other relief to which such party shall be entitled.

17.3 **Assignment and Subletting**. Lessee shall not assign this Lease or any interest herein, whether by operation of law or otherwise, or sublet the Leased Premises or any part thereof, without the prior written consent of the Lessor, except in the event that the assignee or sublessee pays to the Lessor by cash or by certified check (i) the remainder of Rent due under the Lease (such Rent to be computed as of the effective date of the assignment or sublease) and (ii) a security deposit of one full year's Rent. Notwithstanding the foregoing, the option to extend this Lease for an additional seven (7) year term (as set forth in Section 1.2 hereof) is specific to Lessee and shall not be included in any assignment or sublease or be transferable to any other party in any other manner. Lessor may freely assign this Lease with notice to Lessee.

17.4 **Notice**. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered, delivered by prepaid certified mail, return receipt requested or delivered by a nationally recognized overnight delivery service (e.g. Federal Express or Airborne), addressed as follows;

To Lessor: Telegraph Realty LLC

To Lessee: Comprehensive at Orleans LLC
14012 Route 31 West
Albion, NY 14411

Or, to such other address, and to the attention of such other person or officer as any party may designate, with copies thereof to the respective counsel thereof as notified by such party.

17. 5 **Waiver/Remedies Cumulative**. Any failure or delay by Lessor to exercise any right or remedy under this Lease shall not be deemed a waiver of such right or remedy, and no right or remedy of Lessor shall be deemed to be waived unless expressly waived in writing by Lessor. The waiver of any right or remedy by Lessor hereunder shall not constitute or operate as a waiver of any future similar right or remedy. All rights, powers, options, elections and remedies of Lessor herein contained shall be construed as cumulative and no one of them as exclusive of any other or exclusive of any rights or remedies as are or shall be allowed Lessor at law or in equity.

17.6 **Severability**. In the event any provision of this Lease is held to be invalid, illegal or unenforceable for any reason and in any respect, such invalidity, illegality or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Lease, which shall be and remain in full force and effect, enforceable in accordance with its terms.

17.7 **Post-Commencement Date access to Information**. Lessee acknowledges that subsequent to the Commencement Date Lessor may need access to information or documents in the control or possession of Lessee for legitimate purposes. Accordingly, Lessee agrees that subsequent to the Commencement Date Lessee will make available to Lessor's agents, independent auditors and/or governmental agencies such documents and information in respect of the Leased Premises to the extent necessary to facilitate audits, compliance with governmental requirements and regulations and the prosecution or defense of claims or for other legitimate purposes. The parties hereto agree that Lessee shall maintain resident records and other records of the Facility.

17.8 **Relationship of Parties**. Nothing contained in this Lease shall be deemed or construed by the parties hereto or by any third person to create the relationship of principal and agent, partnership or joint venture or of any association between Lessor and Lessee, and no provision contained in this Lease or any acts of the parties hereto shall be deemed to create any relationship between Lessor and Lessee other than the relationship of Lessor and Lessee. In addition, notwithstanding anything herein to the contrary, nothing herein is intended for the benefit of any third parties and no person or entity other than Lessor or Lessee or their successors or assigns shall have any rights of anything contained herein.

17.9 **Revenues**. During the Lease Term, all revenues and income derived from the operation of the Facility shall be the property of Lessee.

17.10 **Choice of Law and Venue**. The parties agree that this Lease shall be governed by and construed in accordance with the laws of the State of New York, and that the courts of such state shall be the exclusive courts of jurisdiction and venue for any litigation, special proceeding or other proceeding as between the parties that may be brought, or arise out of, in connection with or by reason of this lease.

17.11 **Gender, Number**. Whenever the context of this Lease requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

17.12 **Amendment**. No changes in or amendments to this Lease shall be recognized unless and until made in writing and signed by all parties hereto or them respective successors and assigns. This Lease may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. This Lease amends and supersedes any and all prior leases between Lessor and Lessee.

17.13 **Binding Effect**. The terms of this Lease shall be binding upon, and shall inure to the benefit of and be enforceable by and against, the heirs, successors and assigns of the parties hereto.

17.14 **Time of the Essence**. Time is of the essence of this Lease, and each and every covenant, term, condition and provision hereof.

17.15 **Divisions and Headings**. The divisions of this Lease and the use of captions and headings in connection therewith are solely for convenience and shall have no legal effect in construing the provisions of this Lease.

17.16 **Licensure and Right to Operate**. Notwithstanding any other provision of this Lease, it is understood and agreed that, upon the termination or expiration of this Lease, the rights and privileges regarding the operation of the Facility, including, but not limited to, any licenses, certifications, and certificates of need for the Facility, provided Landlord, or its designee files a complete application for Public Health Counsel ("PHC") establishment approval under article 28 of the Public Health Law, be approved by the PHC, and be issued its own operating certificate by the Department of Health, shall revert to, and become vested in Lessor or its designee to the extent permitted by the applicable governmental authorities and by operation of law. Lessee hereby represents, warrants, agrees and covenants that, in the event of the foregoing, it shall execute any and all documents and do all other things necessary, to the extent permitted by the applicable governmental authorities and by operation of law, to transfer, assign and convey to the Lessor or its designee any and all licenses, certifications, certificates of need and any and all other rights and privileges regarding the Facility, to be effective upon the later of (i) termination or expiration of the Lease or (ii) issuance of an operating certificate by the Department of Health to Landlord or its designee. Lessor and Lessee agree and acknowledge that this paragraph of the Lease may be cited to any regulatory agency or governmental body as evidence and confirmation of the parties' mutual intent that the Lessor or its designee shall have, hold and retain any licenses, certifications, certificates of need and all rights and privileges regarding the Facility, from and after the date on which this Lease expires or is terminated. Such intent is to be carried out only upon the receipt of all governmental approvals. In the event that at any time during the term thereof an application is made for the appointment of a receiver to operate the Facility, Lessee shall cooperate in all respects and make all possible requests, demands and/or take any necessary legal action to ensure the appointment of Lessor or its designee as receiver.

IN WITNESS WEREOF, Lessor and Lessee have executed the foregoing Lease.

Telegraph Realty LLC (LESSOR)

By_____

Comprehensive at Orleans LLC (LESSEE)

By_____

EXHIBIT 50

LEASE AGREEMENT

LEASE AGREEMENT (the "Lease"), by and between Telegraph Realty LLC ("Lessor") and Comprehensive at Orleans LLC ("Lessee").

WITNESSETH

WHEREAS, Lessor owns a 120-bed Skilled Nursing Facility currently known as The Villages of Orleans Health and Rehabilitation Center which is located at 14012 Route 31 West, Albion, New York (the "Facility"); and

WHEREAS, Lessor desires to lease to Lessee, and Lessee desires to lease from Lessor, the Facility and the other real and personal property, equipment and interests described in this Lease on the terms and conditions described below;

NOW, THEREFORE, in consideration of the mutual promises, covenants and agreements contained in this Lease, and other good valuable consideration, the receipt and sufficiency of which are acknowledged and confessed, the parties, intending to be legally bound, agree as follows:

ARTICLE I
LEASE

1.1 **Leased Premises.** Lessor hereby leases, rents and lets unto Lessee, and Lessee hereby leases, rents and hires from Lessor, for the Lease Term (as hereinafter defined) and subject to all the covenants and conditions hereinafter stated, all rights, title and interest of Lessor in and to the following (collectively, "the Leased Premises"):

1.1.1 All of the real property upon which the Facility is located (the "Real Property"), including without limitation the building and fixtures (the "Buildings") located thereon, together with all tenements, hereditaments, rights, privileges, interests, easements and appurtenances now or hereafter belonging or in any way pertaining to the Real Property, Buildings and/or the Facility. The Real Property is more particularly described on Exhibit 1.1.1.

1.1.2 All equipment, furniture, inventory (to which Lessor has lawful title, specifically including, but not limited to, office supplies, other supplies and foodstuffs (hereinafter the "Inventory"), appliances, tools, instruments, and other tangible personal property owned by Lessor as of the date of this Lease, and located on the Real Property (the "Personal Property").

1.2 **Lease Term**. The term of this Lease shall commence as the closing date of pursuant to the Facility Transition Agreement between the County of Orleans and Lessee (the "Commencement Date"), and expire on the 10 year anniversary of the Commencement Date, unless sooner terminated as hereinafter provided (the "Lease Term"). Notwithstanding anything in this Lease to the contrary, the commencement of

the Lease is contingent upon Lessee's receiving all necessary authorizations and consents which, in the sole discretion and option of Lessee, are necessary or desirable for Lessee to obtain in order to operate the Facility. Such authorizations include, but are not limited to (a) any necessary or required governmental or regulatory licenses, certifications or other consents and (b) any necessary or required consents or authorizations from any mortgages or lenders of the Facility or of the Lessor. The Lease is also conditioned upon the Lessor obtaining title and possession of the Leased Premises.

ARTICLE II
LEASE PAYMENTS AND OTHER FINANCIAL CONSIDERATIONS

2.1 **Rent**. During the Lease Term, Lessee covenants and agrees to pay, as lease payments hereunder, the monthly Debt Service as set forth on Exhibit A plus Fifty Thousand ($50,000) Dollars per month (the "Rent') plus Lessee's profits of up to One Million ($1,000,000) Dollars per annum. The Rent shall be due and payable on or before the first day of each month.

In addition to the foregoing, Lessee shall pay all taxes due of any sort relating to the Leased Premises including but not limited to all real estate and personal property tax. It shall likewise pay for all insurance and for all repairs to the Leased Premises as is reasonably required by Lessor to maintain the Leased Premises in a condition which is substantially the same as the condition thereof on the Commencement Date.

It is understood and agreed that Lessor shall be obligated to make any mortgage payments relating to the Leased Premises as said payments become due. In the event that Lessor fails to make such mortgage payments, Lessee may make the mortgage payments and Lessee shall be entitled to deduct from the Rent the amount of such mortgage payments actually paid by Lessee.

ARTICLE III
USE OF LEASED PREMISES/COMPLIANCE WITH LAW

3.1 **Use of Premises**. During the Lease Term, Lessee shall use the Leased Premises for the sole and exclusive purpose of operating a nursing home, which shall be continuously open and operating. The Lessee shall operate the Facility in accordance with standards at least equal to those prescribed by all governmental bodies having jurisdiction over (i) the Facility and/or (ii) its eligibility to receive reimbursement or other payment from public funds with respect to services rendered to patients eligible to benefit from any public program providing for such reimbursement or other payment and shall at all times operate the Facility in a manner consistent with the zoning laws then in effect and the certificate of occupancy.

3.2 **Compliance with the Law**. Lessee shall maintain and conduct Lessee's business on the Leased Premises in a lawful manner and shall timely and fully comply with all federal, state and local laws, statutes and ordinances and all regulations, orders

and directives of appropriate governmental and accrediting agencies, as such laws, statutes, ordinances, regulations, orders and directives now existing or that may hereafter be enacted, and, at Lessee's sole cost and expense, make any repairs, changes or modifications in or to the Leased Premises required by any of the foregoing.

3.3 **Waste; Nuisance**. Lessee shall not perform or fail to perform any acts or carry on or permit to exist any practices that may injure or damage the Leased Premises in any respect or that may constitute a public or private nuisance or menace to the owners or occupants of adjacent property, or that may violate the provisions of any required insurance on the Leased Premises or that may diminish the coverage under such insurance or render such insurance void. Lessee shall not commit or suffer to exist any waste upon the Leased Premises.

3.4 **Liens.** Lessee shall not permit any Liens upon the Leased Premises.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF LESSOR

Lessor hereby warrants and represents to Lessee, as of the date of this Lease, that:

4.1 **Authority**. Lessor has full power and authority to execute and to deliver this Lease and all related documents, and to carry out the transaction contemplated herein. This Lease is valid, binding and enforceable against Lessor in accordance with its terms. The execution of this Lease and the consummation of the transaction contemplated herein do not result in a breach of the terms and conditions of, nor constitute a default under, nor violation of any law, regulation, court order, mortgage, note, bond, indenture, agreement, license or other instrument or obligation to which Lessor is now a party or by which Lessor or any of the assets of Lessor may be bound or affected.

4.2 **Title**. Lessor has good and insurable fee simple title to the real property identified and described on Exhibit 1.1.1 hereto, subject only to the easements, reservations and encumbrances of record, those which an accurate survey would disclose or which are identified in the Title Report or schedule thereto ("Permitted Exceptions"), and has good and insurable title to the personal property to be leased to Lessee under the term of this Lease. Lessor warrants that so long as Lessee is not in default hereunder, Lessee shall have quiet enjoyment of the Leased Premises.

4.3 **The Facility**. The Facility is a Residential Health Care Facility ("RHCF") with a total of 120 operational and licensed beds and the personal property used to operate the RHCF at full capacity.

4.4 **Licensure**. The Facility is a duly and properly licensed RHCF with 120 beds. As of the Commencement Date there shall be no action pending or, to the best knowledge of Lessor, recommended by the appropriate state or federal agency having

jurisdiction thereof, to terminate the participation with any agency or program, nor shall there be any decision not to renew any provider agreements related to the RHCF, or any actions of any other type which would have an adverse and material effect on the Facility, its operations or business except as disclosed to Lessee.

4.5 **Intentionally Deleted.**

4.6 **Intentionally Deleted**.

4.7 **Compliance with Law**. Lessor is not aware of any notice of any claim, requirement of demand of any licensing or certifying agency supervising or having authority over the Facility or otherwise to rework or redesign it or to provide additional furniture, fixtures, equipment or inventory so as to conform to or comply with any existing law, code or standard which has not been fully satisfied prior to the date hereof.

4.8 **Litigation**. To the best of Lessor's knowledge, there is no litigation, investigation or other proceeding pending or threatened against Lessor, its properties or business, which involves or relates to the Premises or the Facility, and the transaction contemplated herein has not been challenged by any governmental agency or any other person.

ARTICLE V
REPRESENTATIONS AND WARRANTIES OF LESSEE

Lessee hereby warrants and represents to Lessor, as of the date of this Lease and continuing up to and throughout the Lease Term, that:

5.1 **Status of Lessee**. Lessee is a limited liability company duly organized and validly existing under the laws of the State of New York, and is qualified to do business in the State of New York.

5.2 **Authority**. Lessee has full power and authority to execute and to deliver this Lease and all related documents, and to carry out the transactions contemplated herein. This Lease is valid, binding and enforceable as against Lessee in accordance with its terms. The execution of this Lease and the consummation of the transaction contemplated herein do not result in a breach of the terms and conditions nor constitute default under or violate Lessee's Articles of Organization or any law, regulations, Court order, mortgage, note, bond, indenture, agreement, license or other instrument or obligation to which Lessee is a party or by which Lessee or any of the assets of Lessee may be bound or affected.

5.3 **Litigation**. To the best of Lessee's knowledge there is no litigation, investigation or other proceeding pending or threatened against or in relation to Lessee,

its properties or business which is material to this Lease, nor does Lessee know or have reasonable grounds to know of any business for any such action.

5.4 **Necessary Action**. Lessee has taken all action necessary to enter into this Lease and to carry out the terms of this Lease.

5.5 **Taxes**. Lessee has filed all tax returns (federal, state and local) required to be filed and paid all taxes shown thereon to be due, including interest and penalties, other than such taxes that Lessee is contesting in good faith by appropriate legal proceedings and proper reserves have been established on the books of the Lessee.

5.6 **Liens**. There are no liens, charges or encumbrances upon or with respect to any of the properties of Lessee or right to receive revenues of Lessee other than Permitted Liens.

5.7 **Conflicts**. Lessee is not a party to any indenture, loan or credit agreement or any lease or other agreement or instrument (including company charters or other organizational documents) which is likely to have a material adverse effect on the ability of Lessee to perform its obligations under the Lease or which would restrict or otherwise limit the incurring of the debt arising under this Lease.

5.8 **Compliance with Laws; Licensure.** Lessee is in material compliance with all laws, orders, regulations and ordinances of all federal, foreign, state and local governmental authorities binding upon or materially affecting the business, operation or assets of Lessee or has a plan of correction in place accepted by the State of New York to promptly cure such violations. Lessee has not (i) had a civil monetary penalty assessed against it under the Social Security Act ("SSA") § 1128(a), (ii) been excluded from participation under the Medicare program or under a State health care program as defined in SSA §1128 (h) ("State Health Care Program"), or (iii) been convicted (as that term is defined in 42 C.F.R. §1001.2) of any of the following categories of offenses as described in SSA §1127(a) and (b) (1), (2), (3): (A) criminal offenses relating to the delivery of an item of service under Medicare or any State Health Care Program; (B) criminal offenses under federal or state law relating to patient neglect or abuse in connection with the delivery of a health care item or service; (C) criminal offenses under federal or state law relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any federal, state or local government agency; (D) federal or state laws relating to the interference with or obstruction of any investigations into any criminal offense described in (A) through (C) above; or (E) criminal offenses under federal or state law relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance. Lessee holds all necessary licenses, permits and certifications required by any applicable governmental authority to operate and maintain a nursing home with 120 skilled beds, which is qualified to participate in both Medicare and Medicaid reimbursement programs without limitation, suspension or revocation of privileges. Lessee has materially complied with all applicable requirements of the United

States of America, the State of New York and all applicable local governments, and of its agencies and instrumentalities, to manage the Facility as it is to be operated. Lessee shall file all cost reports required to be filed with respect to the Facility's nursing home operations and the same shall be accurate in all material respects and in compliance with all applicable governmental rules and regulations. Lessee shall be in substantial compliance with and maintain provider agreements under Title XVII and XIX of the Social Security Act for reimbursement for long term nursing care and is qualified to participate in both Medicare and Medicaid reimbursement programs.

5.9 **Solvency.** Lessee has capital sufficient to carry on its business and transactions and all businesses and transactions in which it is about to engage and is solvent and able to pay its debts as they mature. No transfer of property is being made and no debt is being incurred in connection with the transactions contemplated by this Agreement with the intent to hinder, delay or defraud either present or future creditors of Lessee.

5.10 **Debt**. As of the date of this Agreement, Lessee does not have any debt except for loans made by Lessor to Lessee.

5.11 **Accuracy of Information.** To the best of Lessee's knowledge after a due and diligent investigation, all factual information heretofore or contemporaneously furnished by or on behalf of Lessee to Lessor for the purposes of satisfying the provisions of or in connection with this Agreement or any transaction contemplated hereby is, and all other factual information (taken as a whole) hereafter furnished by or on behalf of Lessee to Lessor will be, to the best of Lessee's knowledge after a due and diligent investigation, true and accurate in every material respect on the date as of which such information is dated or certified, and Lessee has not omitted and will not omit any material fact necessary to prevent such information from being false or misleading. Lessee has disclosed to Lessor, in writing, all facts which Lessee has knowledge of and which Lessee believes is more likely than not to materially and adversely affect the business, credit, operations or financial condition of Lessee or which Lessee believes is more likely than not to materially and adversely affect any material portion of Lessee's property, or Lessee's ability to perform its obligations under the Lease.

ARTICLE VI
MAINTENANCE AND REPAIR

6.1 **Maintenance and Repair**. Throughout the Lease Term, Lessee, at Lessee's sole cost and expense, shall keep and maintain the Leased Premises and all parts thereof in good working order and condition, ordinary wear and tear excepted, including but not limited to, the maintenance, repair and replacement, if necessary, of the roof, foundation, all structural components, the heating, ventilation and air conditioning system of the Facility and all plumbing, electrical and equipment systems of the Facility and the grounds, driveways, walkways, paving and parking lots of the Leased Premises. Lessee

acknowledges that Lessor shall have no obligations concerning repairs to or maintenance of the Leased Premises.

ARTICLE VII
EQUIPMENT

7.1 **Lessor's Equipment**. All equipment, furniture and furnishings on hand as of the Commencement Date and which are not tagged or marked by Lessee as Lessee's equipment shall constitute a part of the Leased Premises and shall be and remain the personal property of Lessor ("Lessor's Equipment").

7.2 **Lessee's Equipment**. All equipment, fixtures, and furnishings acquired by Lessee and not constituting Lessor's Equipment shall be and remain the personal property of Lessee ("Lessee's Equipment") and shall be tagged or marked by Lessee as such.

7.3 **Disposition of Obsolete Equipment**. Lessor and Lessee recognize that portions of Lessor's Equipment may become inadequate, obsolete, worn out, unsuitable, undesirable or unnecessary in the operation of the Leased Premises. In any instance in which Lessee in its sole discretion determines that any items of Lessor's Equipment has become inadequate, obsolete, worn out, unsuitable, undesirable or unnecessary in the operation of the Leased Premises, Lessee may remove such items of Lessor's Equipment from the Leased Premises, and on behalf of Lessor sell, trade-in, exchange or otherwise dispose of same without any responsibility or accountability to Lessor thereof; provided, however, that Lessee shall substitute and install in the Leased Premises other equipment having equal or greater utility (but not necessarily the same function) in the operation of the Leased Premises, and provided further that such removal and substitution shall not impair the operations of the Leased Premises. All such substitute equipment shall constitute Lessor's Equipment and shall be held by Lessee on the same terms and conditions as items originally comprising Lessor's Equipment. Lessee shall execute and deliver to the Lessor such documents as may from time to time be requested to confirm the title of the Lessor to any items of Lessor's Equipment. Lessee will not remove or permit the removal of any Lessor's Equipment from the Leased Premises except in accordance with the provisions in this Section.

ARTICLE VIII
TAXES AND UTILITIES

8.1 **Taxes**. From and after the Commencement Date, Lessee shall be responsible for and shall pay prior to delinquency any and all taxes, assessments, charges, and all other amounts demanded from any governmental and/or quasi-governmental agency for or relating to the Leased Premises including, but not limited to, ad valorem taxes assessed against the Leased Premises, and any and all federal, state or local taxes incurred or assessed in connection with Lessee's operation of the Leased Premises,

including, without limitation, federal and state income taxes, franchise taxes, FICA, FUTA and other unemployment taxes. It shall not be a defense that such tax, assessment or charge was not in existence or contemplated at the time of the execution of this Agreement.

8.2 **Utilities**. Lessee shall be solely responsible for and shall pay all charges for utilities in respect of the Leased Premises, including, without limitation, charges for water, gas, electricity, sewer service, refuse disposal, telephone service and similar services incurred in connection with the operation of the Leased Premises during the Lease Term.

ARTICLE IX
INSURANCE

9.1 **General Requirements**. Lessee, at the sole cost and expenses of Lessee, covenants to obtain and maintain throughout the Lease Term a commercial property policy covering Building, Contents and Business Income interruption. Such policy shall, at Lessor's option, be payable to the Lessee and Lessor and any mortgagee of Lessor, as their interest may appear. Lessee shall furnish to Lessor a certificate showing that such policy is in effect and premiums therefor have been paid. Upon written notice of Lessor, Lessee shall also be required to obtain any insurance which is commercially reasonable at Lessee's expense for the benefit of Lessor and/or its lenders.

9.2 **Cancellation/Certification**. Certificates of insurance evidencing such coverage shall be delivered to Lessor prior to the Commencement Date and annually thereafter prior to expiration of the then-current policy terms.

ARTICLE X
DAMAGE, DESTRUCTION AND CONDEMNATION

10.1 **Damage or Destruction**. Should the building upon the Leased Premises be totally or partially destroyed by fire or other cause, the damage shall be repaired and the building restored with the proceeds of the insurance provided for in Article IX of the Lease. Should the building be damaged by any cause whatsoever, so that rebuilding or repairs are not completed within six (6) months of the occurrence of such damage, this Lease may be terminated at the option of the Lessee. Lessee shall be allowed an equitable abatement of the rent during such time as it is unable to enjoy the use of the whole or part of the Leased Premises.

10.2 **Condemnation**. In the event that all or any part of the Leased Premises shall be taken or damaged by the exercise of the power of eminent domain, then (whether or not this Lease shall terminate by operation of law upon such exercise of the power of eminent domain) the respective interest of the Lessor and Lessee in and to the Leased Premises by reason of such exercise of power and eminent domain shall be separately determined and computed by the Court having jurisdiction and separate awards and

judgments with respect of such damage to the Lessor and Lessee, respectively, and to each of such respective interest, shall be made and entered. The Lessor shall receive and retain the full amount of such damages to be determined whether or not such amount is in its favor or in favor of the Lessee. In the event the Leased Premises is so substantially and permanently taken by the power of eminent domain as to make the Leased Premises in the reasonable and good faith opinion of the Lessee unsuitable for continuing the operation of the Facility, then this Lease may be terminated by the Lessee, as of the effective date of the taking, by notice given by Lessee to Lessor. Any such termination shall be without prejudice to any claim of Lessee against the condemning authority for damages resulting to Lessee from such condemnation. In the event the Leased Premises shall be partially and permanently taken by the power of eminent domain but in the reasonable and good faith opinion of Lessee, Lessor and any of its lenders, if such consent is required by any loan documents then in effect, the uncondemned portion of the Leased Premises is suitable for continuing the operation of the Facility, then this Lease shall not terminate and Lessor shall repair the Leased Premises, with an equitable abatement of the monthly rent commensurate with a proportionate percentage reduction in income to Lessee as a result of the taking.

ARTICLE XI
SURRENDER OF POSSESSION

11.1 **Surrender**. Upon the expiration or termination of the Lease Term, howsoever effected, Lessee shall forthwith surrender the Leased Premises to Lessor, free and clear of all claims, liens, security interests and other encumbrances (except Permitted Encumbrances and other encumbrances approved in writing by Lessor during the Lease Term) and in as good working order and condition as on the Commencement Date, ordinary wear and tear excepted. Lessor's Equipment and all inventory acquired by Lessee during the Lease Term and on hand as of the date of expiration or termination shall also be surrendered to Lessor and all equipment and inventory surrendered shall have an aggregate functional capability at least equal to the aggregate functional capability of the equipment and inventory existing at the Facility as of the Commencement Date, Lessee may remove Lessee's Equipment from the Leased Premises upon the expiration or termination of the Lease Term; provided, however, that Lessee shall be responsible for and shall immediately repair any damage to the Leased Premises caused by the removal of Lessee's Equipment.

ARTICLE XII
DEFAULT AND LEASE TERMINATION

12.1 **Events of Default of Lessee**. Each of the following acts, omissions or occurrences shall constitute an "Event of Default of Lessee" hereunder:

A. Failure by Lessee to pay or cause to be paid, within ten (10) business days of the date required, rent specified to be paid under Section 2.1 hereof or any other monetary amount due to Lessor;

B. The vacating of the Leased Premises by Lessee;

C. Failure of Lessee to observe and perform any covenant, condition or agreement of Lessee under this Lease, other than a breach addressed in Section 12.1(A) above, within ten days (10) after the date Lessee receives written notice of such failure of performance, or, with respect to failures of performance not susceptible of cure within ten (10) days upon approval in writing by the Lessor, the failure of Lessee to thereafter diligently prosecute same to completion and/or cure the same within sixty (60) days;

D. Lessee shall make a transfer in fraud to creditors or shall make an assignment for the benefit of creditors;

E. Lessee shall file a petition under any section or chapter of the United States Bankruptcy Code, as amended, or under any similar law or statue of the United States or any state thereof, or Lessee shall be adjudged bankrupt or insolvent in proceeding filed against Lessee thereunder;

F. The filing or execution or occurrence (or contemplation thereof) of any of following: (i) the appointment of a trustee or receiver to take possession of substantially all of Lessee's assets or of Lessee's leasehold estate in the Leased Premises; or (ii) the judicial seizure of substantially all of Lessee's assets or Lessee's leasehold estate in the Leased Premises; or

G. Any representation or warranty of Lessee is breached or is false or misleading in any material respect when made or which becomes false during the pendency of this Lease.

12.2 **Remedies of Lessor**. Upon the occurrence and continuance of any Events of Default of Lessee specified in the foregoing Section 12.1, Lessor shall have the option to pursue any one or a combination of the following remedies without any notice to or demand upon Lessee whatsoever provided however Lessor must notify the Commissioner of its intent to exercise its remedies hereunder and remove the licensed Operator from the premises in accordance with 10 NYCRR§ 401.3:

A. Terminate this Lease, in which event Lessee shall immediately notify the Commissioner of the Department of Health (the "Commissioner") of its intention to surrender its operating certificate pursuant to 10 NYCRR §401.3 ninety (90) days prior to the surrender of the Leased Premises to Lessor, and if Lessee fails to so notify the Commissioner, Lessor shall notify the Commissioner of its intention to terminate this Lease and take possession of the Leased Premises. If Lessee fails to surrender the

Leased Premises after receipt of the Commissioner's written approval of the Lessee's surrender of its operating certificate, Lessor may, without prejudice to any other remedy which Lessor may have, expel or remove Lessee and any other person who may be occupying the Leased Premises, or any part thereof, at Lessee's expense. In such event Lessor may, in addition to the foregoing, seek such other damages and remedies as are available at law or in equity for Lessee's breach of this Lease.

B. Enter upon and take possession of the Leased Premises and expel or remove Lessee and any other person who may be occupying Leased Premises, at Lessee's expense, or any part thereof, at Lessee's expense, without terminating this Lease, and exercise reasonable efforts to re-let the Leased Premises, as Lessee's agent, at the highest rent then obtainable and receive the rent therefor; and Lessee covenants and agrees to pay Lessor on demand any cost or expense incurred by Lessor in connection with re-letting the Leased Premises and any deficiency in Rent that may arise by reason of such re-letting. In no event shall Lessee be entitled to any profit made from any re-let or be relieved of any obligation to make rent payments in the event the party re-letting fails to do so.

C. Enter upon the Leased Premises and, at Lessee's expense, take such actions as may be required of Lessee to cure the complained of default; and Lessee covenants and agrees to reimburse Lessor on demand for any expense, direct or indirect, which Lessor may incur in thus effecting compliance with Lessee's obligations under this Lease.

D. Pursuit of any of the foregoing remedies shall not preclude pursuit of any other foregoing remedies or of the other remedies herein provided or any other remedies provided at law or in equity, nor shall pursuit of any remedy herein provided constitute a forfeiture or waiver of any Rent or other amounts due to Lessor hereunder or of any damages accruing to Lessor by reason of the violation of any of the terms, provisions or covenants herein contained. No waiver by Lessor of any violation or breach of any of the terms, provisions or covenants herein contained shall be deemed or construed to constitute a waiver of any other violation or breach of any of the terms, provisions or covenants herein contained. Forbearance by Lessor to enforce one or more of the remedies herein provided upon an Event of Default of Lessee shall not be deemed or construed to constitute a waiver of such default.

E. To the extent any amounts due to Lessor under the terms of this Lease, whether as a result of an Event of Default or otherwise, are

not timely paid, such amounts shall bear interest at the rate of eighteen percent (18%) per annum from the date such amounts were due until paid to Lessor.

12.3 **Events of Default of Lessor**. Each of the following acts, omissions or occurrences shall constitute an "Event of Default of Lessor" hereunder:

A. Failure of Lessor to observe and perform any material covenant, condition or agreement of Lessor under this Lease within ten days (10) after the date Lessor receives written notice of such failure of performance, or, with respect to failure of performance not susceptible of cure within ten (10) days upon approval in writing by the Lessee, the failure of Lessor to commence a cure within said ten (10) day period and to thereafter diligently prosecute same to completion;

B. Lessor shall make a transfer in fraud to creditors or shall make an assignment for the benefit of creditors;

C. Lessor shall file a petition under any section or chapter of the United States Bankruptcy Code, as amended, or under any similar law or statute of the United States or any state thereof or Lessor shall be adjudged bankrupt or insolvent in proceedings filed against Lessor hereunder; or

D. The filing or execution or occurrence (or contemplation thereof) of any of the following: (i) the appointment of a trustee or receiver to take possession of substantially all of Lessor's assets or of Lessor's leasehold estate in the Leased Premises; or (ii) the judicial seizure of substantially all of Lessor's assets or of Lessor's leasehold estate in the Leased Premises.

12.4 **Remedies of Lessee.** Upon the occurrence and continuance of any of the Events of Default of Lessor specified in the foregoing Section 12.3, Lessee shall have the option to pursue any one or combination of the following remedies without any notice to or demand upon Lessor whatsoever:

A. Terminate this Lease, in which event Lessee shall surrender the Leased Premises to Lessor upon notice to Lessor without further remedy.

B. Take such actions as may be required of Lessor from time to time to cure the complained of default; and Lessor covenants and agrees to reimburse Lessee on demand for any expenses, direct or indirect, which Lessee may incur in thus effecting compliance with

Lessor's obligations under this Lease. Lessee may not deduct amounts due hereunder from payments due to Lessor.

Pursuit of any foregoing remedies shall not preclude pursuit of any of the other foregoing remedies or of the other remedies herein provided or any other remedies provided at law or in equity. No waiver by Lessee of any violation or breach of any of the terms, provisions or covenants herein contained shall be deemed or construed to constitute a waiver of any other violation or breach of any of the terms, provisions or covenants herein contained. Forbearance by Lessee to enforce one or more of the remedies herein provided upon an Event of Default of Lessor shall not be deemed or construed to constitute a waiver of such default. To the extent any amounts due to Lessee under the terms of this Lease, whether as a result of an Event of Default of Lessor or otherwise, are not timely paid, such amounts shall bear interest at the rate of seven percent (7%) per annum from the date such amounts were due until paid to Lessee.

12.5 **Department of Health Notification.** Notwithstanding anything to the contrary contained herein:

The Lessor acknowledges that its rights of reentry into the Leased Premises set forth in this Lease do not confer on it the authority to operate a hospital as defined in article 28 of the Public Health law on the Leased Premises and agrees that it will give the New York State Department of Health, Tower Building, Empire State Plaza, Albany, N.Y. 12237, notification by certified mail of its intent to reenter the Leases Premises or to initiate dispossess proceedings or that the Lease is due to expire, at least 30 days prior to the date on which the Lessor intends to exercise a right of reentry or to initiate such proceedings or at least 60 days before the expiration of the Lease. Upon receipt of notice from the Lessor of its intent to exercise its right of reentry or upon the service of process in dispossess proceedings and 60 days prior to the expiration of the Lease, the Lessee shall immediately notify by certified mail the New York State Department of Health, Tower Building, Empire State Plaza, Albany, NY 12237, of the receipt of such notice or service of such process or that the Lease is about to expire.

ARTICLE XIII
PROHIBITION AGAINST LIENS

13.1 **Prohibition Against Liens.** Lessee covenants that it will not create any lien, encumbrance or charge upon the Leased Premises, Rent payable hereunder, or any part of either of the foregoing, and that it will satisfy or cause to be discharged, within thirty (30) days after the same shall accrue, all lawful claims and demands for labor, materials, supplies or other items which, if not satisfied, might by law become a lien upon Lessee's leasehold estate in the Leased Premises or Rent payable hereunder or any part of either. If any such lien shall be filed against Lessee's leasehold estate in the Leased

Premises, or asserted against Rent or any amounts due hereunder, by reason of work, labor or services or asserted against Rent, by or to the Facility at the request of the Lessor with the permission of Lessee, Lessee shall, within fifteen (15) days after notice is received of the filing thereof or the assertion thereof against the Lessee's leasehold estate in the Leased Premises or Rent, by contest, payment, deposit, bond, order of Court or otherwise. Nothing in this Section 13.1 shall require the Lessee with an opinion of independent counsel that failure to satisfy or discharge such charge, claim or demand in such manner that the interest of Lessor, in the opinion of independent counsel, is not jeopardized. In no event and under no circumstances shall Lessee cause or suffer to exist any lien against or encumbrance upon Lessor's interest in the Leased Premises.

13.2 **Permitted Liens**. Notwithstanding any provision of this Lease to the contrary but without limiting Lessee's obligation to timely pay Rent and other amounts due and payable by Lessee hereunder, Lessee may create or permit to be created the following liens or encumbrances with respect to Lessee's leasehold interest in the Leased Premises ("Permitted Liens"):

A. Liens granted in connection with any improvements, expansion, extension, additions or modifications of the Facility or any real property adjacent thereto.

B. Any liens, charges, encumbrances and restrictions which may be created or exist by reason of this Lease or loan from Lessor.

C. Liens, charges and encumbrances for taxes or assessments or other government charges or levies not then delinquent.

ARTICLE XIV
LIABILITIES AND INDEMNIFICATION

14.1 **Liabilities**. It being understood that Lessor is simultaneously purchasing and leasing the Leased Premises, Lessee shall assume any and all obligations or liabilities of the Lessor, the Facility or any obligation or liability relating to the Lessor or to the Facility, of any nature whatsoever (whether express or implied, fixed or contingent, liquidated or unliquidated, known or unknown, accrued or unaccrued, due or to become due), relating to any period prior to the termination or expiration of this Lease except such obligation or liability caused by Lessor's gross negligence or intentional wrongdoing.

14.2 **Indemnification**. Lessee agrees to and does hereby indemnify and hold the Lessor, its officers, directors, agents, employees and lenders harmless from and against any claims, demands, causes of action, liability, loss, damage, deficiency, cost or expense (including, without limitation, reasonable attorney's fees and associated costs and expenses) resulting from (i) the acts or omissions of Lessee and Lessee's employees,

agents, independent contractors, guests, invitees or any other persons or thing in respect of the Facility or caused in whole or in part by breach of this Agreement, (ii) any misrepresentation, breach of warranty or non-fulfillment of any agreement, representation, warranty or condition by or on the part of Lessee under this Lease, or (iii) any liability asserted against Lessor, its officers, directors, agents, employees and Lenders in any way relating to the Lessee or to the Facility except those liabilities specifically assumed herein by Lessor.

ARTICLE XV
INSPECTION

15.1 **Inspections**. Lessor and Lessor's agents, insurers, lenders and/or representatives shall have the right to enter and inspect the Leased Premises during normal business hours.

ARTICLE XVI
ACCESS TO RECORDS AND REPORTING REQUIREMENTS OF LESSEE

16.1 **Access**. The Lessor shall have access to records of the Lessee, which are determined by mutual agreement of the parties to be reasonably necessary for the Lessor to be able to ensure that the Lessee is complying with the terms and conditions set forth herein. Notwithstanding anything provided herein to the contrary, Lessor shall not have access to review patient medical records in possession of the Lessee without the specific consent of such patients and/or without complying strictly with all local, State, and Federal laws, rules, and regulations relating to the protection of confidential patient records.

16.2 **Reporting Requirements of Lessee**. Lessee shall keep true books of record and account in which full, true and correct entries in accordance with GAAP consistently applied will be made of all dealings or transactions in relation to its business and activities, and an authorized member of Lessee shall furnish to Lessor:

(i) as soon as possible and in any event within ten (10) days after the occurrence of an Event of Default or any event which, with the giving of notice, lapse of time, or both, would constitute an Event of Default, and if requested by Lessor, a statement of an authorized member of Lessee setting forth details of such Event of Default or event and the action which Lessee has taken or proposes to take to cure the same;

(ii) as soon as reasonably available and in any event within seventy-five (75) days after the end of each calendar quarter, internally-prepared financial statements of Lessee, including a Balance Sheet and the related Income Statement as of the end of such quarter and for the portion of the fiscal year ended at the end of such quarter, setting forth in each case in comparative form the figures for the corresponding quarter and the corresponding portion of the previous fiscal year,

all in reasonable detail and certified (subject to normal year-end adjustments) as to fairness of presentation, in accordance with GAAP, by Lessee's managing member;

(iii) as soon as reasonably available and in any event within one hundred twenty (120) days after the close of each fiscal year, a combined and combining Balance Sheet and the related Income Statement as of the end of such fiscal year, fairly and accurately presenting the financial condition of Lessee at such date and the results of operations of Lessee for such fiscal year and setting forth in each case in comparative form the corresponding figures for the corresponding period of the preceding fiscal year, all in reasonable detail, prepared in accordance with GAAP consistently applied, compiled and reviewed, in each case, by an independent certified public accountant acceptable to Lessor and Lessee. For the purposes of this provision, Jay Bakst, CPA, is deemed to be acceptable to Lessor and Lessee. Lessor may, but is not required to, hire an independent certified public accountant of its choosing, at Lessee's own expense to verify the foregoing;

(iv) at Lessor's request, a schedule showing the accounts receivable agings delivered to Lessor within thirty (30) days after the end of each month;

(v) promptly upon receipt and, in any event, within thirty (30) days after receipt thereof, copies of all interim and supplemental financial reports submitted to Lessee by independent certified public accountants in connection with any interim review of the books and records of Lessee made by such accountants;

(vi) as soon as available and in any event within fifteen (15) days after filing, copies of all cost reports filed with Medicaid or any other applicable state or federal agency;

(vii) within fifteen (15) days of Lessor's request, a copy of the most recent annual or biannual certification survey report and any statement of deficiencies with plans of correction attached thereto;

(viii) immediately after notice to Lessee of the commencement thereof, notice, in writing, of any action, suit, arbitration or other proceeding instituted, commenced or threatened against or affecting the Lessee with an amount in controversy in excess of $100,000;

(ix) as soon as available and in any event within fifteen days of filing, Lessee's federal, state and local tax returns, if and as applicable, as soon as said returns are completed in the form said returns will be filed with the Internal Revenue Service and any state or local department of revenue or taxing authority; and

(x) such other information respecting the condition or operations, financial or otherwise, of Lessee as Lessor may from time to time reasonably request, including, without limitation, annual public aid rate updates, monthly accounts

receivable aging reports, cost reports, annual survey reports and budget and cash flow projections.

ARTICLE XVII
MISCELLANEOUS PROVISIONS

17.1 **Additional Assurances.** The provisions of this Lease shall be self-operative and shall not require further agreement by the parties except as may be provided herein to the contrary; provided, however, at the request of either party, the other party shall execute such additional instruments and take such additional acts as may reasonably be necessary to effectuate this Lease,

17.2 **Legal Fees and Costs.** In the event either Lessor or Lessee institute any proceedings to enforce or interpret any provision of this Lease, the prevailing party will be entitled to recover its legal expenses, including, without limitation, reasonable attorney's fees, costs, and necessary disbursements, in addition to any other relief to which such party shall be entitled.

17.3 **Assignment and Subletting**. Lessee shall not assign this Lease or any interest herein, whether by operation of law or otherwise, or sublet the Leased Premises or any part thereof, without the prior written consent of the Lessor, except in the event that the assignee or sublessee pays to the Lessor by cash or by certified check (i) the remainder of Rent due under the Lease (such Rent to be computed as of the effective date of the assignment or sublease) and (ii) a security deposit of one full year's Rent. Notwithstanding the foregoing, the option to extend this Lease for an additional seven (7) year term (as set forth in Section 1.2 hereof) is specific to Lessee and shall not be included in any assignment or sublease or be transferable to any other party in any other manner. Lessor may freely assign this Lease with notice to Lessee.

17.4 **Notice**. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered, delivered by prepaid certified mail, return receipt requested or delivered by a nationally recognized overnight delivery service (e.g. Federal Express or Airborne), addressed as follows;

To Lessor: Telegraph Realty LLC

To Lessee: Comprehensive at Orleans LLC
14012 Route 31 West
Albion, NY 14411

Or, to such other address, and to the attention of such other person or officer as any party may designate, with copies thereof to the respective counsel thereof as notified by such party.

17. 5 **Waiver/Remedies Cumulative**. Any failure or delay by Lessor to exercise any right or remedy under this Lease shall not be deemed a waiver of such right or remedy, and no right or remedy of Lessor shall be deemed to be waived unless expressly waived in writing by Lessor. The waiver of any right or remedy by Lessor hereunder shall not constitute or operate as a waiver of any future similar right or remedy. All rights, powers, options, elections and remedies of Lessor herein contained shall be construed as cumulative and no one of them as exclusive of any other or exclusive of any rights or remedies as are or shall be allowed Lessor at law or in equity.

17.6 **Severability**. In the event any provision of this Lease is held to be invalid, illegal or unenforceable for any reason and in any respect, such invalidity, illegality or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Lease, which shall be and remain in full force and effect, enforceable in accordance with its terms.

17.7 **Post-Commencement Date access to Information**. Lessee acknowledges that subsequent to the Commencement Date Lessor may need access to information or documents in the control or possession of Lessee for legitimate purposes. Accordingly, Lessee agrees that subsequent to the Commencement Date Lessee will make available to Lessor's agents, independent auditors and/or governmental agencies such documents and information in respect of the Leased Premises to the extent necessary to facilitate audits, compliance with governmental requirements and regulations and the prosecution or defense of claims or for other legitimate purposes. The parties hereto agree that Lessee shall maintain resident records and other records of the Facility.

17.8 **Relationship of Parties**. Nothing contained in this Lease shall be deemed or construed by the parties hereto or by any third person to create the relationship of principal and agent, partnership or joint venture or of any association between Lessor and Lessee, and no provision contained in this Lease or any acts of the parties hereto shall be deemed to create any relationship between Lessor and Lessee other than the relationship of Lessor and Lessee. In addition, notwithstanding anything herein to the contrary, nothing herein is intended for the benefit of any third parties and no person or entity other than Lessor or Lessee or their successors or assigns shall have any rights of anything contained herein.

17.9 **Revenues**. During the Lease Term, all revenues and income derived from the operation of the Facility shall be the property of Lessee.

17.10 **Choice of Law and Venue**. The parties agree that this Lease shall be governed by and construed in accordance with the laws of the State of New York, and that the courts of such state shall be the exclusive courts of jurisdiction and venue for any

litigation, special proceeding or other proceeding as between the parties that may be brought, or arise out of, in connection with or by reason of this lease.

17.11 **Gender, Number**. Whenever the context of this Lease requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

17.12 **Amendment**. No changes in or amendments to this Lease shall be recognized unless and until made in writing and signed by all parties hereto or them respective successors and assigns. This Lease may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. This Lease amends and supersedes any and all prior leases between Lessor and Lessee.

17.13 **Binding Effect**. The terms of this Lease shall be binding upon, and shall inure to the benefit of and be enforceable by and against, the heirs, successors and assigns of the parties hereto.

17.14 **Time of the Essence**. Time is of the essence of this Lease, and each and every covenant, term, condition and provision hereof.

17.15 **Divisions and Headings**. The divisions of this Lease and the use of captions and headings in connection therewith are solely for convenience and shall have no legal effect in construing the provisions of this Lease.

17.16 **Licensure and Right to Operate**. Notwithstanding any other provision of this Lease, it is understood and agreed that, upon the termination or expiration of this Lease, the rights and privileges regarding the operation of the Facility, including, but not limited to, any licenses, certifications, and certificates of need for the Facility, provided Landlord, or its designee files a complete application for Public Health Counsel ("PHC") establishment approval under article 28 of the Public Health Law, be approved by the PHC, and be issued its own operating certificate by the Department of Health, shall revert to, and become vested in Lessor or its designee to the extent permitted by the applicable governmental authorities and by operation of law. Lessee hereby represents, warrants, agrees and covenants that, in the event of the foregoing, it shall execute any and all documents and do all other things necessary, to the extent permitted by the applicable governmental authorities and by operation of law, to transfer, assign and convey to the Lessor or its designee any and all licenses, certifications, certificates of need and any and all other rights and privileges regarding the Facility, to be effective upon the later of (i) termination or expiration of the Lease or (ii) issuance of an operating certificate by the Department of Health to Landlord or its designee. Lessor and Lessee agree and acknowledge that this paragraph of the Lease may be cited to any regulatory agency or governmental body as evidence and confirmation of the parties' mutual intent that the Lessor or its designee shall have, hold and retain any licenses, certifications, certificates of need and all rights and privileges regarding the Facility, from and after the date on which this Lease expires or is terminated. Such intent is to be carried out only upon the receipt of all governmental approvals. In the event that at any time during the term thereof an application is made for the appointment of a receiver to operate the Facility, Lessee shall cooperate in all respects and make all possible requests, demands and/or take any necessary legal action to ensure the appointment of Lessor or its designee as receiver.

IN WITNESS WEREOF, Lessor and Lessee have executed the foregoing Lease.

Telegraph Realty LLC (LESSOR)

By_____

Comprehensive at Orleans LLC (LESSEE)

By Ronald Fuchs

EXHIBIT 51

Schedule 1 A - General Information - All Applicants

Main Site

PROJECT SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME	
0716	00308998	RHCF	The Villages of Orleans Health and Rehabilitation Center	
STREET & NUMBER				
14012 Route 31				
CITY			COUNTY	ZIP
Albion			Orleans	14411

Project Site

PROJECT SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME	
0716	00308998	RHCF	The Villages of Orleans Health and Rehabilitation Center	
STREET & NUMBER				
14012 Route 31				
CITY			COUNTY	ZIP
Albion			Orleans	14411

Operator Information

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)	
3620300	RHCF	Comprehensive at Orleans, LLC	
STREET & NUMBER			
150 Motor Parkway, Suite 401			
CITY		COUNTY	ZIP
Hauppauge		Suffolk	11788

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☐ NO ☒	
Is the applicant part of an "established article 28* network" as defined in section 401.1(j) of 10 nycrr? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart, if available.	YES ☐ NO ☒	

Type of Application: Establishment ☒ Construction ☐ Administrative ☐ Limited ☐

Total Project Cost:	$3,000
Amount of Application Fee (see Schedule 8)	$3,000

Acknowledgement and Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant: Comprehensive at Orleans, LLC. I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of articles 28, 36 and 40 of the public health law and/or article 7 of the social services law, and implementing regulations, as the case may be.

SIGNATURE: Bernard Fuchs	DATE
	3/19/14
PRINT OR TYPE NAME	TITLE
Bernard Fuchs	Member

New York State Department of Health
Certificate of Need Application

Schedule 1A

Contacts:

Applicant should identify the operator's chief executive officer, or equivalent official, to whom all official correspondence from DOH about this application should be addressed

CHIEF EXECUTIVE			
NAME AND TITLE OF CHIEF EXECUTIVE			
Bernard Fuchs			
STREET & NUMBER			
[redacted]			
CITY	STATE	ZIP	
[redacted]	NY	11559	
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS	
[redacted]	[redacted]	[redacted]	

Applicant may designate a second person to whom copies of all official correspondence from DOH about this application should be addressed. (This could be the applicant's attorney, or a consultant)

CONTACT INFORMATION		
CONTACT PERSON'S COMPANY	NAME AND TITLE OF CONTACT PERSON	
Loeb & Troper LLP	Deborah Lynch, Principal	
STREET & NUMBER		
655 Third Avenue, 17th Floor		
CITY	STATE	ZIP
New York	NY	10017
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
212-697-3000	212-697-8893	dlynch@loebandtroper.com

The applicant's lead attorney should be identified:

ATTORNEY		
NAME		
Rosenbaum & Associates		
STREET & NUMBER		
4 Canaan Circle		
CITY	STATE	ZIP
South Salem	New York	10590
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
914-232-1005	845-675-5022	trosenbaum@rosemontlaw.com

If a consultant prepared the application, the consultant should be identified:

CONSULTANT		
NAME		
Deborah Lynch, Principal, Loeb & Troper		
STREET & NUMBER		
655 Third Avenue, 17th Floor		
CITY	STATE	ZIP
New York	NY	10017
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
212-697-3000	212-697-8893	dlynch@loebandtroper.com

The applicant's lead accountant should be identified:

ACCOUNTANT	NAME		
	Bonadio and Co., LLP		
	STREET & NUMBER		
	6400 Sheridan Drive, Suite 230		
	CITY	STATE	ZIP
	Williamsville	NY	14221
	TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
	716-633-8885		

Checklist of Schedules Included in This Application

Schedule Number	Schedule Name	Required	Included
1 (A-C)	Forms Required for all CON Applications	☒	☒
2 (A-D)	Personal Qualifying and Disclosure Information-All Establishment Applications	☒	☒
3 (A-B)	CON Forms Related to Legal Issues	☒	☒
4 (A-B	Legal Information for Ownership Transfers	☒	☒
5	CON Form Regarding Working Capital Plan	☒	☒
6	CON Form Regarding Architectural Submission	☐	☐
7	CON Form Regarding Environmental Issues	☐	☐
8 (A-B)	Project & Subproject Cost Summary	☐	☐
9	CON Form Regarding Project Financing	☒	☒
10	Space & Construction Cost Distribution	☐	☐
11	Movable Equipment	☐	☐
12 (A-G)	CON Forms Specific to Adult Care Facilities	☐	☐
13 (A-D)	CON Forms Applicable to all Article 28 Facilities	☒	☒
14 (A-D)	Additional Legal Information – Article 28	☒	☒
15	Additional Legal Information – Article 28 Ownership Transfers	☒	☒
16 (A-F)	CON Forms Specific to Hospitals – Article 28	☐	☐
17 (A-E)	CON Forms Specific to Diagnostic & Treatment Centers – Article 28	☐	☐
18 (A-E)	CON Forms Specific to Residential Health Care Facilities – Article 28	☒	☒
19 (A-B)	CON Forms Specific to Adult Day Health Care Programs	☐	☐
20 (A-C)	CON Forms Specific to Programs of OMH, OASAS and OMRDD (If Applicable)	☐	☐
21 (A-G)	CON Forms Specific to CHHA and LTHHCP Programs – Article 36	☐	☐
22 (A-F)	CON Forms Specific to Hospices – Article 40	☐	☐
23	CON Forms Specific to All Projects Incorporating Health IT	☐	☐

Schedule 1 B — Abbreviated Executive Summary

Instructions:

In the space below, i.e., no more than one page, provide a succinct overview of your proposal. This may be done in bullet format. The purpose of the Abbreviated Executive Summary (AES) is to give the reviewer a conceptual understanding of the proposal. The AES should summarize the key elements of the proposed project. Details will be contained in the appropriate schedules of the application.

ABBREVIATED EXECUTIVE SUMMARY

This Certificate of Need (CON) application seeks approval of the Public Health and Health Planning Council to establish a new operator of The Village of Orleans Health and Rehabilitation Center (Orleans), an existing 120-bed county owned residential health care facility (RHCF) located in Orleans County.

The proposed change of ownership will replace the current operator, Orleans County, with Comprehensive at Orleans, a limited liability corporation. The members of Comprehensive at Orleans are:

Member	Membership Percentage
Bernard Fuchs	100%

The County of Orleans (which operates the nursing facility) entered into a Facility Transition Agreement with Comprehensive at Orleans (the proposed Operator) on February 6, 2014. On March 8, 2013, the County had entered into a Lease agreement with the Orleans County Health Facilities Corporation (OCHFC), giving the latter a lease with an exclusive option to purchase the facility. OCHFC has entered into a purchase and sale agreement to sell the nursing facility to Comprehensive (the proposed Operator) and Telegraph Realty, LLC (real property purchaser).

The Department's draft 2016 RHCF need estimates indicate that there is unmet need for 50 RHCF beds in Orleans County and therefore, the continuation of needed nursing facility care through this new operator supports the frail and elderly community of Orleans County. The change of ownership will ensure that cost efficiencies are achieved while maintaining and continuing Orleans' mission of caring for the frail-elderly in its community.

Schedule 1 C — Other Facilities Owned or Controlled by the Applicant

(Establishment Applications only)

Does the applicant or any related entity (parent, member or subsidiary corporation) operate or control any of the following in New York State?

FACILITY TYPE — NEW YORK STATE	FACILITY TYPE CODE	
Hospital	HOS	Yes ☐ No ☒
Nursing Home	NH	Yes ☒ No ☐
Diagnostic and Treatment Center	DTC	Yes ☐ No ☒
Licensed Home Care Services Agency	LHH	Yes ☐ No ☒
Certified Home Health Agency	CHH	Yes ☐ No ☒
Hospice	HSP	Yes ☐ No ☒
Adult Home	ADH	Yes ☐ No ☒
Assisted Living Program	ALP	Yes ☐ No ☒
Long Term Home Health Care Program	LTC	Yes ☐ No ☒
Enriched Housing Program	EHP	Yes ☐ No ☒
Health Maintenance Organization	HMO	Yes ☐ No ☒
Other	OTH	Yes ☐ No ☒

For each facility or agency referenced above, enter the name, the PFI and facility type in the chart below.

	FACILITY NAME:	PFI	FACILITY TYPE
1	Bensonhurst Center for Rehabilitation and Healthcare	1406	RHCF
2	Hopkins Center for Rehabilitation and Healthcare	5546	RHCF
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

EXHIBIT 52

New York State Department of Health
Certificate of Need Application

Schedule 2 - Worksheet

Table 2A-1 Personal Information Tracking

*** Refer to the instructions on Worksheet Pages 1 and 2 to determine who should submit Schedule 2 and then enter the names accordingly on the following worksheet. Attach additional sheets if necessary. Attachment #_____.**

Legal Operator - List Stockholder(s), Officer(s), Director(s), LLC Member(s) or Directors or Manager(s) or Partners(s) Under Each Entity Named	Title or Position That Requires This Individual to Submit Schedule 2	Mark "X" if Required to Submit this Schedule		
		2A	2B	2C
Bernard Fuchs	LLC Member	☒	☒	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

* Please note exception for CHHAs on prior pages.

Schedule 2A - Personal Qualifying Information

Name of Individual:

Bernard Fuchs

1. Personal Identifying Information

LAST NAME	FIRST NAME	MIDDLE INITIAL
Fuchs	Bernard	

STREET ADDRESS
[redacted]

CITY	STATE	ZIP CODE	TELEPHONE
[redacted]	NY	11559	[redacted]

BUSINESS NAME AND ADDRESS
Tiferes Investors LLC 101 Fulton Street

CITY	STATE	ZIP CODE	TELEPHONE
Lawrence	NY	11559	[redacted]

DATE OF BIRTH (Month/Day/Year)	PLACE OF BIRTH (County/State)	Social Security #
[redacted]	[redacted]	[redacted]

CURRENT OR PROPOSED POSITION WITH PROPOSED ORGANIZATION
Member of LLC

2. Formal Education

INSTITUTION	ADDRESS	ATTENDED FROM	ATTENDED TO	DEGREE	DATE RECEIVED
Torah Vodaath Talmudic Seminary	425 East 9th St B'klyn NY 11218	9/1/1963	6/1/1967	Talmudic Studies	6/1/1967

3. Licenses Held - N/A

Type of Professional License & License Number (Include Specialty)	Institution Granting License (Mailing Address, Phone & E-mail)	Effective Date	Expiration Date

4. Employment History for the Past 10 Years

Currently Employed ☒ Retired ☐

If retired, please specify date of retirement: ☐

Start with MOST RECENT employment and include employment during the last 10 years. A resume or curriculum vitae (CV) may be substituted for this portion of the application but any additional information requested below and not contained in such resume or CV should be added. Please photocopy and attach additional sheets, if necessary.

NAME OF EMPLOYER		TYPE OF BUSINESS
Tiferes Investors LLC		Investment related activities
STREET ADDRESS OF EMPLOYER		
101 Fulton Street		
CITY	STATE	ZIP CODE
Lawrence	NY	11559
DATES OF EMPLOYMENT	FROM	TO:
	1/1/2006	present
POSITION/RESPONSIBILITIES		
CEO and Chief Investment Officer		
REASON FOR DEPARTURE		
n/a presently employed		

NAME OF EMPLOYER		TYPE OF BUSINESS
Lenoxx Electronics		Electronics Importer
STREET ADDRESS OF EMPLOYER		
1271 60th St		
CITY	STATE	ZIP CODE
Brooklyn	NY	11219
DATES OF EMPLOYMENT	FROM	TO:
	9/1/1975	1/1/2006
POSITION/RESPONSIBILITIES		
President/ Importer of electronics, which were sold to Fortune 500 retailers		
REASON FOR DEPARTURE		
Company was sold.		

NAME OF EMPLOYER		TYPE OF BUSINESS
STREET ADDRESS OF EMPLOYER		
CITY	STATE	ZIP CODE
DATES OF EMPLOYMENT	FROM	TO:
POSITION/RESPONSIBILITIES		
REASON FOR DEPARTURE		

5. Offices Held or Ownership in Health Facilities

The purpose of this section is to obtain a listing of any affiliations as referenced below with which the owners, officers, directors, controlling persons or partners of the proposed organization have been associated in the past 10 years. Affiliation, for the purposes of this section, includes serving as either a voting officer, director or principal stockholder of any health care, adult care, behavioral or mental health facility, program or agency requiring licensure or certification in New York State. Officerships and directorships in similar facilities or programs outside of New York State must also be disclosed. Include facilities for which applications were previously disapproved or withdrawn.

Provide documentation from the appropriate regulatory agency in the states (other than New York State) where you note affiliations, reflecting that the affiliated facilities, programs and agencies operated in substantial compliance with applicable codes, rules and regulations for the past ten years (or for the period of your affiliation, whichever is shorter). Instructions for the out-of-state review, a sample letter of inquiry and a recommended form are provided in Schedule 2D to assist you in securing this information.

a. Applicant's Offices/Ownership Interests

From	To	Name of Facility	Address of Facility	Type of Facility
1/1/2006	8/31/2010	Hudson Pointe	3220 Henry Hudson Parkway,Riverdale NY 10463	Nursing and Rehab
Office Held/Nature of Interest		**Name of Licensing Agency**		**Address of Licensing Agency**
50% owner		NY State – Department of Health		161 Delaware Avenue Delmar, N.Y. 12054

From	To	Name of Facility	Address of Facility	Type of Facility
3/24/2011	Present	Hopkins Center for Rehab	155 Dean St. Brooklyn, NY 11217	SNF
Office Held/Nature of Interest		**Name of Licensing Agency**		**Address of Licensing Agency**
Member		NYSDOH		Albany, NY

From	To	Name of Facility	Address of Facility	Type of Facility
1/19/12	Present	Bensonhurst Center for Rehab	1740 84th St. Brooklyn, NY 11214	SNF
Office Held/Nature of Interest		**Name of Licensing Agency**		**Address of Licensing Agency**
Member		NYSDOH		Albany, NY

From	To	Name of Facility	Address of Facility	Type of Facility
Office Held/Nature of Interest		**Name of Licensing Agency**		**Address of Licensing Agency**

From	To	Name of Facility	Address of Facility	Type of Facility
Office Held/Nature of Interest		Name of Licensing Agency		Address of Licensing Agency

b. Relative's Ownership Interests – N/A

Name of relative and relationship to the applicant:				
Name:			Relationship:	
From	To	Name of Facility	Address of Facility	Type of Facility
Office Held/Nature of Interest		Name of Licensing Agency		Address of Licensing Agency

Name of relative and relationship to the applicant:				
Name:			Relationship:	
From	To	Name of Facility	Address of Facility	Type of Facility
Office Held/Nature of Interest		Name of Licensing Agency		Address of Licensing Agency

Name of relative and relationship to the applicant:				
Name:			Relationship:	
From	To	Name of Facility	Address of Facility	Type of Facility
Office Held/Nature of Interest		Name of Licensing Agency		Address of Licensing Agency

Name of relative and relationship to the applicant:				
Name:			Relationship:	
From	To	Name of Facility	Address of Facility	Type of Facility
Office Held/Nature of Interest		Name of Licensing Agency		Address of Licensing Agency

Name of relative and relationship to the applicant:				
Name:			Relationship:	
From	To	Name of Facility	Address of Facility	Type of Facility
Office Held/Nature of Interest		Name of Licensing Agency		Address of Licensing Agency

c. Enforcement Actions

During the period of your (or your relative's) affiliation, were any of the facilities subject to an enforcement or administrative action taken by the State regulatory agency due to the facility's violation of applicable laws and regulations? **Yes** ☐ **No** ☒

If "Yes, Please provide the following Information:

NATURE OF VIOLATION
AGENCY OR BODY ENFORCING VIOLATION (Name & Address)

Has the enforcement or administrative action been resolved? **Yes** ☐ **No** ☐

If "No", provide an explanation

d. Affirmative Statement of Qualifications

For individuals who have not previously served as a director/officer nor have had managerial experience with a health facility/agency, please provide in the space below an affirmative statement explaining why you are qualified to operate the proposed facility/agency. This statement should include, but not be limited to, any relevant community/volunteer background and experience.

6. Record of Legal Actions

1) Except for minor traffic violations, have you ever been convicted of, or had a sentence imposed for, a crime?	Yes ☐ No ☒
2) Are there any criminal actions pending against you?	Yes ☐ No ☒
3) Have you ever been named as a defendant in any civil action, including but not limited to malpractice, fraud or breach of fiduciary responsibility	Yes ☐ No ☒
4) Are there now or have there ever been any civil or administrative actions pending against you involving Medicaid or Medicare issues?	Yes ☐ No ☒
5) Are there now or have there ever been any civil or administrative actions pending against you or any professional/business entity with which you are affiliated?	Yes ☐ No ☒
6) Are there now or have there ever been any insurance arbitration awards against you or any professional/business entity with which you are affiliated?	Yes ☐ No ☒
7) Have you ever been involved in a hearing before an official body in relation to the operation of a home or institution caring for people?	Yes ☐ No ☒

If the answer to any of the above questions is "Yes," complete the section below:

DATE OF ACTION Month/Day/Year	TYPE OF ACTION	LOCATION OF ACTION
PERSONS AND/OR FACILITIES INVOLVED		
GIVE ANY FURTHER DETAILS		

8) Have you ever changed your name or used an alias?	Yes ☐ No ☒
If Yes, provide details below:	

9) During the last 10 years, have you been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period been suspended, revoked or otherwise subjected to administrative action?	Yes ☐ No ☒
10) Have you ever been involved in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of any securities, insurance or health law or regulation?	Yes ☐ No ☒
11) Have you ever been an officer, director, trustee, member, manager, partner, management employee or stockholder of a company, including the applicant company, where you occupied any such position or served in any such capacity wherein the company:	
a) became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship?	Yes ☐ No ☒
b) was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation?	Yes ☐ No ☒
c) was the subject of an investigation by either federal or state law enforcement agencies on issues related to Medicare or Medicaid fraud?	Yes ☐ No ☒
d) was required to enter into a Corporate Integrity Agreement as part of a settlement with the Office of Inspector General of the U.S. Department of Health and Human Services?	Yes ☐ No ☒
e) suffered the suspension or revocation of its certificate of authority or license to do business in any state?	Yes ☐ No ☒
f) was denied a certificate of authority or license to do business in any state?	Yes ☐ No ☒
If the answer is "yes to Questions 9, 10, or 11 attach an explanation, including, where applicable, the date, type, and location of the action, and all relevant details.	
Have you ever been in a position that required a fidelity bond?	Yes ☐ No ☒
Were any claims made against that bond? If "Yes", provide details below	Yes ☐ No ☐
Have you ever been denied a fidelity bond or had such fidelity canceled or revoked?	Yes ☐ No ☒
If "Yes", provide details below	

The undersigned hereby certifies, under penalty of perjury, that the above stated information is true, correct and complete.

SIGNATURE	DATE
X Bernard Fuchs	3/17/14
PRINT OR TYPE NAME	
Bernard Fuchs	
TITLE	

NOTARY	DATE
Joel Edelstein	3/17/14

Has the original of this document been signed and notarized? Yes ☒ No ☐

JOEL EDELSTEIN
NOTARY PUBLIC-STATE OF NEW YORK
No. 01ED6212176
Qualified in Nassau County
My Commission Expires October 13, 2017

Schedule 2B - Personal Financial Statement

To be filled out by sole proprietors, general partners, LLC members and managers, shareholders, officers and directors of business corporations and directors of not-for-profit corporations who contributel capital. Directors of not-for-profit corporations who do not contribute capital should complete Schedule 2C instead.

N.B. Exceptions for CHHAs are in schedule 2A.

LAST NAME	FIRST NAME	MIDDLE INITIAL
Fuchs	Bernard	

STREET ADDRESS
[redacted]

CITY	STATE	ZIP CODE	TELEPHONE	SOCIAL SECURITY NO
[redacted]	NY	11559		[redacted]

BUSINESS OR PROFESSION
Investor

NAME OF EMPLOYER
Tiferes Investors LLC

LIST OTHER BUSINESS VENTURES IN WHICH YOU ARE A PARTNER OR AN OFFICER:
Mr. Fuchs is a partner of the investment manager of Platinum Partners, an investment management group with more than $1 Billion in assets under management.

SALARY	
FEES OR COMMISSION	
OTHER (SPECIFY):	9,000,000 partnership income

In the following section, describe any contingent liabilities:
In the following section, describe your business ventures:

1. Balance Sheet: Summarizes from following sections as of March 1, 2014

ASSETS		LIABILITIES	
Cash (Section II)	782,000	Notes Payable (Section VII)	
Stocks and Bonds (Section III)	32,016,000	A. Banks	0
Accounts Receivable		B. Relatives	0
Notes Receivable		C. Health Care Facility	0
A. Due from Relatives and Friends		D. Other (Specify)	0
B. Due from others – Good (Deposit)	6,461,000	Accounts Payable	
C. Due from others - Doubtful		A. Health Care Facilities	0
Real Estate Owned (Section V)	6,000,000	B. Other (Specify)	0
Cash Surrender Value of Life Insurance		Mortgages Payable	
Health Facility Realty Interests	7,275,000	A. Health Care Facilities	0
Health Facility Operational Interests	7,275,000	B. Other (Specify)	0
Business Interests (Itemize) (Section VIII):		Federal and State Income Taxes Payable	0
1		Other Accrued Taxes & Interests Payable	0
2		Installment Contracts Payable	0
3		Other Liabilities (Itemize)	
4		1	
5		2	
6		3	
TOTAL	59,809,000	TOTAL	0
AMOUNT OF ASSETS PLEDGED	0.00	AMOUNT OF LIABILITIES SECURED	0

NET WORTH	$ 59,809,000

2. CASH ON HAND

Name of Bank	Account #	Account Balance	Amt. Pledged (if any)
Capital One Bank	[redacted]	82,000	0.00
Capital One Bank	[redacted]	700,000	0.00
Cash on Hand		$782,000	0.00
Total as Per Statement		$782,000	0.00

3. STOCKS AND BONDS

Stock = "S" Bond = "B"	Name of Security (example "US Gov't Series –")	In Name of	If Pledged, State to Whom	Present Market Value
Stocks	[redacted]	Bernard Fuchs		10,255,000
Stocks		Bernard Fuchs		19,900,000
Stocks				762,000
Stocks				1,099,000

4. Real Estate Owned

Location, Type of Property	Date Acquired	Title in Name of	Cost	Recent Appraised Value	Method of Payment	Mortgage amount	
						Original	Current
[redacted] NY (new construction)	2009	Hannah Fuchs	2,000,000	6,000,000	cash	0	0

5. Real Estate Mortgages Owned

Type of Lien (1st, 2nd, 3rd, etc.), Location and Type of Property	Mortgages of Record	Original Amount	Method of Payment	Present Amount

Are there any principle payments, interest or taxes in arrears? Yes ☐ No ☒
Are there any unrecorded assignments: Yes ☐ No ☒
If Yes to either question, please explain below:

6. Life Insurance

Face Amount	Name of Company	Beneficiary	Loans Against Policy	Type of Policy	Cash Value

Are any of the above policies assigned except for loans as above? Yes ☐ No ☐
If Yes, please explain below:

7. Notes Payable

Payable to Whom?	Indicate Method of Borrowing and How Note is Endorsed, Guaranteed or Secured	Interest Rate	Current Balance Due

8. Business Interests

Are any of the assets business interests? If yes, they must be supported by the latest available certified financial statements and/or federal income tax returns for the appropriate entity	Yes	No	Attachment Title(s):
	☐	☒	

The undersigned hereby certifies, under penalty of perjury, that the information contained herein or attached hereto is accurate, true, and complete in all material respects.

Has the original of this document been signed and notarized? Yes ☒ No ☐

SIGNATURE	DATE
X Bernard Fuchs	3/17/14
PRINT OR TYPE NAME	
Bernard Fuchs	
TITLE	
Member	

NOTARY	DATE
Joel Edelman	3/17/14

JOEL EDELMAN
NOTARY PUBLIC-STATE OF NEW YORK
No. 01ED6212176
Qualified in Nassau County
My Commission Expires October 13, 2017

EXHIBIT 53

Schedule 14B Additional Legal Information Article 28 Limited Liability Companies

Instructions:

Article 28 applicants seeking establishment or combined establishment and construction approval that are *limited liability companies* must complete this Schedule in its entirety.

N.B.: Whenever a requested legal document has been amended, modified, or restated, all amendment(s), modification(s) and/or restatement(s) should also be submitted.

I. Articles of Organization

Provisions to the following effect must be included:

A. The name of the LLC which must contain either the words "Limited Liability Company" or the abbreviations "LLC" or "L.L.C.";

B. Designation of the Secretary of State as agent of the LLC for service of process and an address to which the Secretary of State may mail a copy of any such process;

C. How the LLC will be managed and that neither the management structure nor the provision setting forth such structure may be deleted, modified or amended without the prior approval of the New York State Department of Health;

D. If the LLC will be managed by managers who are not members, that the manager may not be changed without the prior approval of the New York State Department of Health;

E. That the powers and purposes of the LLC are limited to the ownership and operation of the Article 28 facility specifically named and the location of the facility by street address, city, town, village or locality and county;

N.B.: The powers and purposes may also include the operation of an Article 36 facility, an Article 40 facility and/or an Article 44 entity if the applicant has received all appropriate approvals and certifications.

F. The location of the principal office of the LLC, which must be the same address as the facility; and

G. That notwithstanding anything to the contrary in the Articles of Organization or the Operating Agreement, transfers, assignments or other dispositions of New York State Department of Health membership interests or voting rights must be effectuated in accordance with section 2801-a(4)(b) of the Public Health Law.

II. Operating Agreement

Provisions to the following effect must be included:

A. That the powers and purposes of the LLC are limited to the ownership and operation of the Article 28 facility specifically named and the location of the facility by street address, city, town, village or locality and county;

B. That notwithstanding anything to the contrary in the Articles of Organization or the Operating Agreement, transfers, assignments or other dispositions of membership interests or voting rights must be effectuated in accordance with section 2801-a(4)(b) of the Public Health Law;

C. How the LLC will be managed and that neither the management structure nor the provision setting forth such structure may be deleted, modified or amended without the prior approval of the Department of Health;

D. If the LLC will be managed by managers who are not members, that the manager may not be changed without the prior approval of the Department of Health; and

E. If the LLC will be managed by managers who are not members, that the following powers are reserved to the members:

(i) direct independent authority over the appointment or dismissal of hospital management-level employees and medical staff;

(ii) approval of hospital operating and capital budgets and independent control of the books and records;

(iii) adoption or approval of hospital operating policies and procedures and independent adoption of policies affecting the delivery of health care services;

(iv) authority over the disposition of assets and authority to incur liabilities not normally associated with day-to-day operations;

(v) approval of certificate of need applications filed by or on behalf of the hospital;

(vi) approval of hospital debt necessary to finance the cost of compliance with operational or physical plant standards required by law;

(vii) approval of hospital contracts for management or for clinical services; and

(viii) approval of settlements of administrative proceedings or litigation to which the hospital is a party.

III. Management

Will the applicant be managed by managers who are not members?

Yes ☐ No ☒

If yes, attach the proposed Management Agreement between the applicant and the manager, which must meet the following requirements and be approved by the Commissioner.

A. The management agreement must include provisions to the following effect:

1. A description of the proposed roles of the members of the Article 28 LLC during the period of the proposed management contract, which must clearly reflect retention by the members of ongoing responsibility for statutory and regulatory compliance,
2. A provision that clearly recognizes that the responsibilities of the members of the Article 28 LLC are in no way obviated by entering into a management agreement and that any powers not specifically delegated to the manager through the provisions of the management agreement remain with the members,
3. The following powers are reserved to the members of the Article 28 LLC:
    i. direct independent authority over the appointment or dismissal of hospital management-level employees and medical staff;
    ii. approval of hospital operating and capital budgets and independent control of the books and records;
    iii. adoption or approval of hospital operating policies and procedures and independent adoption of policies affecting the delivery of health care services;
    iv. authority over the disposition of assets and authority to incur liabilities not normally associated with day-today operations;
    v. approval of certificate of need applications filed by or on behalf of the hospital;
    vi. approval of hospital debt necessary to finance the cost of compliance with operational or physical plant standards required by law;

vii. approval of hospital contracts for management or for clinical services; and

viii. approval of settlements of administrative proceedings or litigation to which the hospital is a party; and that this provision may not be deleted; modified or amended without the prior approval of the Department of Health.

4. The following language:

"Notwithstanding any other provision in this contract, the facility remains responsible for ensuring that any service provided pursuant to this contract complies with all pertinent provisions of Federal, State and local statutes, rules and regulations.",

5. A plan for assuring maintenance of the fiscal stability, the level of services provided and the quality of care rendered by the facility during the term of the management agreement, and

6. Retention of authority by the members of the Article 28 LLC to discharge the manager and its employees from their positions at the facility with or without cause on not more than 90 days' notice. In such event, the facility shall notify the Department in writing at the time the manger is notified. The members of the Article 28 LLC must provide a plan for the operation of the facility subsequent to the discharge of the manager and such plan must be submitted with the notification to the Department.

7. That the manager may not be changed and its responsibilities and obligations under the management agreement may not be subcontracted, assigned or otherwise assumed without the prior approval of the Department of Health;

B. The members of the Article 28 LLC must retain sufficient authority and control to discharge its statutory and regulatory responsibility. The following powers must be specifically reserved to the Article 28 LLC members:

i. Direct independent authority over the appointment or dismissal of the facility's management-level employees and medical staff,

ii. Approval of the facility's operating and capital budgets and independent control of the books and records,

iii. Adoption or approval of the facility's operating policies and procedures and independent adoption of policies affecting the delivery of health care services,

iv. Authority over the disposition of assets and authority to incur liabilities not normally associated with day-to-day operations,

v. Approval of certificate of need applications filed by or on behalf of the facility,

vi. Approval of debt necessary to finance the cost of compliance with operational or physical plant standards required by law,

vii. Approval of the facility's contracts for management or for clinical services, and

viii. Approval of settlements of administrative proceedings or litigation to which the facility is a party;

C. An Article 28 LLC desiring to be managed by managers who are not members must submit a proposed written management agreement to the Department at least 60 days before the intended effective date, unless a shorter period is approved in writing by the Commissioner, due to extraordinary circumstances. In addition, the Article 28 LLC shall also submit, within the same time frame, the following:

1. Documentation demonstrating that the proposed manager holds all necessary approvals to do business within New York,

2. Documentation of the goals and objectives of the management arrangement, including a mechanism for periodic evaluation by the members of the Article 28 LLC of the effectiveness of the arrangement in meeting those goals and objectives,
3. Evidence of the manager's financial stability,
4. Information necessary to determine that the character and competence of the proposed manager, and its principals, officers and directors, are satisfactory, including evidence that all facilities it has managed within New York have provided a substantially consistent high level of care in accordance with applicable statutes and regulations, during the term of any management agreement contract or the period they held an operating certificate, and
5. Evidence that it is financially feasible for the facility to enter into the proposed management agreement for the term of the agreement and for a period of one year following expiration, recognizing that the costs of the agreement are subject to all applicable provisions of Part 86 of 10 NYCRR. To demonstrate evidence of financial feasibility, the facility shall submit projected operating and capital budgets for the required periods. Such budgets shall be consistent with previous certified financial statements and be subject to future audits;

D. During the period between a facility's submission of a request for initial approval of a management contract and disposition of that request, a facility may not enter into any arrangement for management contract services other than a written interim consultative agreement with the proposed manager. Any interim agreement must be consistent with these provisions and submitted to the Department no later than five days after its effective date.

E. The term of a management contract shall be limited to three years and may be renewed for additional periods not to exceed three years only when authorized by the Commissioner. The Commissioner shall approve an application for renewal provided that compliance with this section and the following provisions can be demonstrated:

1. That the goals and objectives of the arrangement have been met within specified time frames,
2. That the quality of care provided by the facility during the term of the arrangement has been maintained or has improved, and
3. That the level of service to meet community needs and patient access to care and services has been maintained or improved.

IV. Membership Certificates

Does the applicant intend to issue membership certificates?

Yes ☐ No ☒

If yes, attach a sample membership certificate including the following legend:

"That notwithstanding anything to the contrary in the Articles of Organization or the Operating Agreement, transfers, assignments or other dispositions of membership interests or voting rights must be effectuated in accordance with section 2801-a(4)(b) of the Public Health Law."

V. Business Corporation Members

Does the applicant have any members which are business corporations?

Yes ☐ No ☒

If yes:

A. Identify each business corporation-member (2^{nd} level member) in the following table:

2nd Level Member:	Address

B. For each business corporation-member, attach the following documentation:

1. A list providing the name, stock interest and percentage ownership interest in the 2nd Level Member and indirect ownership percentage in the Article 28 LLC for each stockholder. (Indirect ownership is determined by multiplying the percentage of ownership in each entity. For example, if A owns 10 percent of a 2nd Level Member which itself owns 80 percent of an Article 28 LLC, A owns an indirect ownership interest of eight percent in the Article 28 LLC.);

N.B.: All stockholders of the 2nd Level Member must be natural persons.

2. A list providing the name and position held for each officer and director; and
3. Certificate of Incorporation. In addition to any other provisions required by the Business Corporation Law, the Certificate of Incorporation of the 2nd Level Member must include provisions to the following effect:
    a. That all stockholders must be natural persons and that this provision may not be deleted, modified or amended without the prior approval of the New York State Department of Health; and
    b. That notwithstanding anything to the contrary in the Certificate of Incorporation or the Bylaws, transfers, assignments or other dispositions of ownership interests or voting rights must be effectuated in accordance with section 2801-a(4)(b) of the Public Health Law and that this provision may not be deleted, modified or amended without the prior approval of the New York State Department of Health.

VI. General or Registered Limited Liability Partnership Members

Does the applicant have any members which are general or registered limited liability partnerships?

Yes ☐ No ☒

If yes:

A. Identify each partnership-member (2nd level member) in the following table:

2nd Level Member:	Address

B. For each partnership-member, attach the following documentation:

1 A list providing the name, partnership interest and percentage ownership interest in the 2nd Level Member and indirect ownership percentage in the Article 28 LLC for each partner. (Indirect ownership is determined by multiplying the percentage of ownership in each entity. For example, if A owns 10 percent of a 2nd Level Member which itself owns 80 percent of an Article 28 LLC, A owns an indirect ownership interest of eight percent in the Article 28 LLC.); and

N.B.: All partners of the 2nd Level Member must be natural persons.

2 The Partnership Agreement of the 2nd Level Member must include provisions to the following effect:

a. That all partners must be natural persons and that this provision may not be deleted, modified or amended without the prior approval of the New York State Department of Health;

b. That transfers, assignments or other dispositions of partnership interests or voting rights must be effectuated in accordance with section 2801-a(4)(b) of the Public Health Law and that this provision may not be deleted, modified or amended without the prior approval of the New York State Department of Health.

VII. Not-for-Profit Corporation Members

Does the applicant have any members which are not-for-profit corporations?

Yes ☐ No ☒

If yes:

A. Identify each not-for-profit corporation-member (2nd Level Member):

2nd Level Member:	Address

B. For each not-for-profit corporation-member, attach the following documentation:

1 A list providing the name and interest or position held for each member, director, and officer;

2 Certificate of Incorporation; and

3 Bylaws.

C. Are any of the following powers reserved to any of the corporation's member(s):

Appointment or dismissal of hospital management-level employees and medical staff, except the election or removal of corporate officers.

Yes ☐ No ☐

Member:

Approval of hospital operating and capital budgets.

Yes ☐ No ☐

Member:

Adoption or approval of hospital operating policies and procedures.

Yes ☐ No ☐

Member:

☐☐Approval of certificate of need applications filed by or on behalf of the hospital

Yes ☐ No ☐

Member:

If yes, attach documentation of approval for this application.

Approval of hospital debt necessary to finance the cost of compliance with operational or physical plant standards required by law.

Yes ☐ No ☐

Member:

Approval of hospital contracts for management or for clinical services.

Yes ☐ No ☐

Member:

Approval of settlements of administrative proceedings or litigation to which the hospital is a party, except approval of settlements of litigation that exceed insurance coverage or any applicable self-insurance fund.

Yes ☐ No ☐

Member:

N.B.: If any of the corporation's members have been or will be delegated any of these powers, the member itself must have or obtain establishment approval as an active 2nd level member. If so, submit Schedule 2A for each individual listed in item B(1) above. Directors who contribute capital in support of the project must also submit Schedule 2B. Directors who do not contribute capital in support of the project must also submit Schedule 2C.

VIII. Limited Liability Company Members

Does the applicant have any members which are also LLCs?

Yes ☐ No ☒

If yes:

A. In the following table, identify each LLC 2nd level member :

2nd Level Member	Address

2nd Level Member	Address

B. For each LLC-member, attach the following documentation:

1 A list providing the name, membership interest and percentage ownership interest in the 2nd Level Member and indirect ownership percentage in the Article 28 LLC. (Indirect ownership is determined by multiplying the percentage of ownership in each entity. For example, if A owns 10 percent of a 2nd Level Member which itself owns 80 percent of an Article 28 LLC, A owns an indirect ownership interest of eight percent in the Article 28 LLC.)

N.B.: All members of the 2nd Level Member must be natural persons.

2 A list of all managers;

3 Articles of Organization; and

4 Operating Agreement.

C. In addition to any other provisions required by the Limited Liability Company Law, the Articles of Organization of the 2nd Level Member must include provisions to the following effect:

1 That all members must be natural persons and that this provision may not be deleted, modified or amended without the prior approval of the New York State Department of Health;

2 That transfers, assignments or other dispositions of membership interests or voting rights must be effectuated in accordance with section 2801-a(4)(b) of the Public Health Law and that this provision may not be deleted, modified or amended without the prior approval of the New York State Department of Health.

D. The Operating Agreement of the 2nd Level Member must include provisions to the following effect:

1 That all members must be natural persons and that this provision may not be deleted, modified or amended without the prior approval of the New York State Department of Health,

2 That notwithstanding anything to the contrary in the Articles of Organization or the Operating Agreement, transfers, assignments or other dispositions of membership interests or voting rights

must be effectuated in accordance with section 2801-a(4)(b) of the Public Health Law and that this provision may not be deleted, modified or amended without the prior approval of the New York State Department of Health; and

3 That, if the 2nd Level Member will be managed by managers who are not members, that the following powers with respect to the ownership and operation of the Article 28 LLC are reserved to the members of the 2nd Level Member:

(i) direct independent authority over the appointment or dismissal of hospital management-level employees and medical staff;

(ii) approval of hospital operating and capital budgets and independent control of the books and records;

(iii) adoption or approval of hospital operating policies and procedures and independent adoption of policies affecting the delivery of health care services;

(iv) authority over the disposition of assets and authority to incur liabilities not normally associated with day-today operations;

(v) approval of certificate of need applications filed by or on behalf of the hospital;

(vi) (approval of hospital debt necessary to finance the cost of compliance with operational or physical plant standards required by law;

(vii) approval of hospital contracts for management or for clinical services; and

(viii) approval of settlements of administrative proceedings or litigation to which the hospital is a party; and that this provision may not be deleted; modified or amended without the prior approval of the Department of Health.

SCHEDULE 14B CHECKLIST OF ATTACHMENTS

DOCUMENT	NA	Atta-ched	Attach-ment number	Electronic Document file name
Management Agreement	☒	☐		
Sample membership certificate	☒	☐		
Business Corporation- Members				
Members	☒	☐		
List of stockholders	☒	☐		
List of officers and directors	☒	☐		
Certificate of Incorporation	☒	☐		
Not-for-Profit Corporation- Members				
Members	☒	☐		
List of members	☒	☐		
List of officers and directors	☒	☐		
Certificate of Incorporation	☒	☐		
Bylaws	☒	☐		
Documentation of approval for the application	☐	☐		
Limited Liability Company - Members				
Members	☒	☐		
List of members	☐	☒	14B.1	
List of managers	☒	☐		
Articles of Organization	☐	☒	3B.3	
Operating Agreement	☐	☒	3B.4	
General or Registered Limited Liability Company - Members				
List of Partners	☒	☐		
Partnership Agreement	☒	☐		

ATTACHMENT 14B.1

LIST OF MEMBERS

Bernard Fuchs: Sole Member, 100% interest

New York State Department of Health
Certificate of Need Application

Schedule 1

General Information - All Applicants

Main Site

MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
0716	00308998	RHCF	The Villages of Orleans Health and Rehabilitation Center

STREET & NUMBER
14012 Route 31

CITY	COUNTY	ZIP
Albion	Orleans	14411

Project Site

PROJECT SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
0716	00308998	RHCF	The Villages of Orleans Health and Rehabilitation Center

STREET & NUMBER
14012 Route 31

CITY	COUNTY	ZIP
Albion	Orleans	14411

Operator Information

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE THE FACILITY (or proposed operator)
3620300	RHCF	Comprehensive at Orleans, LLC

STREET & NUMBER
150 Motor Parkway, Suite 401

CITY	COUNTY	ZIP
Hauppauge	Suffolk	11788

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☐ NO ☒	
Is the applicant part of an "established article 28* network" as defined in section 401.1(j) of 10 nycrr? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart, if available.	YES ☐ NO ☒	

Type of Application: Establishment ☒ Construction ☐ Administrative ☐ Limited ☐

Total Project Cost:	$3,000
Amount of Application Fee (see Schedule 8)	$3,000

Acknowledgement And Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant: The Villages of Orleans Health and Rehabilitation Center

I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of articles 28, 36 and 40 of the public health law and/or article 7 of the social services law, and implementing regulations, as the case may be.

SIGNATURE:	DATE 10/27/11
Bernard Fuchs	
PRINT OR TYPE NAME	TITLE
Bernard Fuchs	Member

Contacts:

Applicant should identify the operator's chief executive officer, or equivalent official, to whom all official correspondence from DOH about this application should be addressed

CHIEF EXECUTIVE			
NAME AND TITLE OF CHIEF EXECUTIVE			
Bernard Fuchs			
STREET & NUMBER			
[redacted]			
CITY	STATE	ZIP	
[redacted]	NY	[redacted]	
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS	
[redacted]	[redacted]	[redacted]	

Applicant may designate a second person to whom copies of all official correspondence from DOH about this application should be addressed. (This could be the applicant's attorney, or a consultant)

CONTACT INFORMATION		
CONTACT PERSON'S COMPANY	NAME AND TITLE OF CONTACT PERSON	
Loeb & Troper	Deborah Lynch, Principal	
STREET & NUMBER		
655 Third Avenue, 17th Floor		
CITY	STATE	ZIP
New York	NY	10017
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
212-697-3000	212-697-8893	dlynch@loebandtroper.com

The applicant's lead attorney should be identified:

ATTORNEY		
NAME		
Rosenbaum & Associates		
STREET & NUMBER		
4 Canaan Circle		
CITY	STATE	ZIP
South Salem	New York	10590
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
914-232-1005	845-675-5022	trosenbaum@rosemontlaw.com

If a consultant prepared the application, the consultant should be identified:

CONSULTANT		
NAME		
Deborah Lynch, Principal, Loeb & Troper		
STREET & NUMBER		
655 Third Avenue, 17th Floor		
CITY	STATE	ZIP
New York	NY	10017
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
212-697-3000	212-697-8893	dlynch@loebandtroper.com

Schedule 1

The applicant's lead accountant should be identified:

ACCOUNTANT

NAME		
Bonadio and Co., LLP		
STREET & NUMBER		
6400 Sheridan Drive, Suite 230		
CITY	STATE	ZIP
Williamsville	NY	14221
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
716-633-8885		

Please list all Architects and Engineer contacts.

ARCHITECT and/or ENGINEER

NAME	FIRM	STREET & NUMBER
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

ARCHITECT and/or ENGINEER

NAME	FIRM	STREET & NUMBER
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

ARCHITECT and/or ENGINEER

NAME	FIRM	STREET & NUMBER
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

ARCHITECT and/or ENGINEER

NAME	FIRM	STREET & NUMBER
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

Other Facilities Owned or Controlled by the Applicant

(Establishment Applications only)

Does the applicant or any related entity (parent, member or Subsidiary Corporation) operate or control any of the following in New York State?

FACILITY TYPE - NEW YORK STATE	FACILITY TYPE CODE	
Hospital	HOSP	Yes ☐ No ☒
Nursing Home	NH	Yes ☒ No ☐
Diagnostic and Treatment Center	DTC	Yes ☐ No ☒
Licensed Home Care Services Agency	LHCSA	Yes ☐ No ☒
Certified Home Health Agency	CHHA	Yes ☐ No ☒
Hospice	HSP	Yes ☐ No ☒
Adult Home	ADH	Yes ☐ No ☒
Assisted Living Program	ALP	Yes ☐ No ☒
Long Term Home Health Care Program	LTHHCP	Yes ☐ No ☒
Enriched Housing Program	EHP	Yes ☐ No ☒
Health Maintenance Organization	HMO	Yes ☐ No ☒
Other	OTH	Yes ☐ No ☒

For each facility or agency referenced above, enter the name, the PFI and facility type in the chart below.

	FACILITY NAME:	PFI	FACILITY TYPE
1	Comprehensive Rehabilitation and Nursing Center at Williamsville	0274	RHCF
2	Bensonhurst Center for Rehabilitation and Healthcare	1406	RHCF
3	Hopkins Center for Rehabilitation and Healthcare	5546	RHCF
4			
5			
6			
7			
8			
9			
10			

Attach additional sheet if necessary.

Facility Id. 716
Certificate No. 3620301N

State of New York
Department of Health
Office of Primary Care and Health Systems Management

Certified Beds - Total **120**
RHCF 120

OPERATING CERTIFICATE

Residential Health Care Facility - SNF

Effective Date: 01/01/2015
Expiration Date: NONE

The Villages of Orleans Health and Rehabilitation Center
14012 Route 31
Albion, New York 14411

Operator: Comprehensive at Orleans LLC
Operator Class: Proprietary LLC

Has been granted this Operating Certificate pursuant to Article 28 of the Public Health Law for the service(s) specified.

Baseline Respite 2

Keith W. Servis

Deputy Director Office of Primary Care and Health Systems Management

Facsimile

Commissioner

20150910

This certificate must be conspicuously displayed on the premises.

Checklist of Schedules Included in This Application

Schedule Number	Schedule Name	Required	Included
1	Forms Required for all CON Applications	☒	☒
2 (A-D)	Personal Qualifying and Disclosure Information-All Establishment Applications	☒	☒
3 (A-B)	CON Forms Related to Legal Issues	☒	☒
4 (A-B)	Legal Information for Ownership Transfers	☒	☒
5	CON Form Regarding Working Capital Plan	☒	☒
6	CON Form Regarding Architectural Submission	☐	☐
7	CON Forms Regarding Environmental Issues	☐	☐
8 (A-B)	Project & Subproject Cost Summary	☐	☐
9	CON Forms Regarding Project Financing	☒	☒
10	Space & Construction Cost Distribution	☐	☐
11	Moveable Equipment	☐	☐
12 (A-G)	CON Forms Specific to Adult Care Facilities	☐	☐
13 (A-D)	CON Forms Applicable to all Article 28 Facilities	☒	☒
14 (A-D)	Additional Legal Information-Article 28	☒	☒
15	Additional Legal Information-Article 28-Ownership Transfers	☒	☒
16 (A-F)	CON Forms Specific to Hospitals-Article 28	☐	☐
17 (A-E)	CON Forms Specific to Diagnostic & Treatment Centers-Article 28	☐	☐
18 (A-E)	CON Forms Specific to Residential Health Care Facilities-Article 28	☒	☒
19 (A-B)	CON Forms Specific to Adult Day Health Care Programs	☐	☐
20 (A-C)	CON Forms Specific to Programs of OMH, OASAS, and OMRDD (If Applicable)	☐	☐
21 (A-G)	CON Forms Specific to CHHA and LTHHCP Programs-Article 36	☐	☐
22 (A-F)	CON Forms Specific to Hospices-Article 40	☐	☐
23	CON Forms Specific to All Projects Incorporating Health IT	☐	☐

This Certificate of Need (CON) application seeks approval of the Public Health and Health Planning Council to expand ownership of The Villages of Orleans Health and Rehabilitation Center from the currently approved one member to eleven members.

This will be achieved through the sale and gifting of shares from the original member to 10 additional members, as shown in the Purchase Option Agreements (Attachment 4A.1). The table below summarizes the proposed change of ownership shares.

Owner	*Percent ownership share approved in original CON (141128)*	*Proposed new share*	*Change in share*	*How accomplished (see Attachment 4A.3 for Purchase Option Agreements)*
Joel Edelstein	0%	3.32%	+3.32%	Gifted
Joshua Farkovits	0%	16.66%	+16.66%	Purchase from B. Fuchs
Israel Freund	0%	3.32%	+3.32%	Gifted
Bernard Fuchs	100%	3.32%	-96.68%	B. Fuchs to sell 75% of shares and gift 21.6%
Gerald Fuchs	0%	3.32%	+3.32%	Gifted
Tova Fuchs	0%	3.32%	+3.32%	Gifted
David Gast	0%	20.99%	+20.99%	Purchase from B. Fuchs
Sam Halper	0%	12.33%	+12.33%	Purchase from B. Fuchs
Debbie Korngut	0%	9.16%	+9.16%	Purchase from B. Fuchs
Ephram Lahasky	0%	16.66%	+16.66%	Purchase from B. Fuchs
Teresa Lichtschein	0%	7.5%	+7.5%	Purchase from B. Fuchs
TOTAL	100%	100%	100%	

This expansion of ownership will ensure financial viability while maintaining and continuing our mission of caring for the frail elderly in the community.

EXHIBIT 55

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

November 16, 2017

Ms. Deborah Lynch
Consultant
Loeb & Troper
655 Third Avenue
New York, NY 10017

Re: 161047
The Villages of Orleans Health and Rehabilitation Center
(Orleans County)
Transfer of 96.68% membership interest from the current sole member to ten new members

Dear Ms. Lynch:

Review of the above application has revealed the need for the submission of the following additional information.

1. Updated and revised Schedule 2A for each member which lists all nursing home operational ownerships as of December 1, 2017.
2. A signed affidavit from Ephram Lahasky, Josh Farkovits and David Gast that they do not have a current or past operational ownership in The Villages of Orleans Health and Rehabilitation Center.
3. A clarification regarding the from Josh Farkovits indicating the correct ownership interest percentage for Birch Manor Nursing Home (MA); the submitted 2A lists two different percentages.
4. Provide an explanation for the low quality ratings for Comprehensive Rehab at Williamsville, Meadow Park Rehab, Waterbury Gardens (CT), Delmar (DE), Center for Advanced Rehab at Parkside (GA),Pearl Valley Rehabilitation (IA), The Grandview Nursing (KY), Ridgeway Nursing (KY), Chicopee Gardens (MA),Fitchburg Gardens (MA), Bayshore Residence (MN), Centennial Gardens (MN), The Gardens at Cannon Falls, (MN), Hamilton Nursing Home (MI), Neptune Gardens (NJ), Health Center at Galloway (NJ), Riverside Nursing (NJ), Brighton Rehab (PA), Ridgeview Healthcare (PA), The Gardens at Lititz (PA), The Gardens at Pottstown (PA), The Gardens at Millville (PA), The Gardens at Orangeville (PA), The Grove at Greenville (PA), The Grove at Irwin (PA), The Grove at New Castle (PA), The Grove at New Wilmington (PA), and Claiborne and Hughes (TN).
5. Describe the quality improvement program which has been implemented to improve the quality of these nursing homes.

6. One signed affidavit per state which lists the health facility operational ownerships and attests to the following:

For all nursing homes and assisted living facilities in (STATE) there have been:

- No survey deficiencies of "G" level or higher;
- No survey deficiencies which resulted in an enforcement action or fine;
- No survey deficiencies which resulted in a declaration of Immediate Jeopardy.

OR

The following nursing homes and assisted living facilities in (STATE) have had:

- Survey deficiencies of "G" level or higher; and/or
- Survey deficiencies which resulted in an enforcement action or fine; and/or
- Survey deficiencies which resulted in a declaration of Immediate Jeopardy.

For each nursing home with survey deficiencies full disclosure must be provided regarding the circumstances of the citation, and the total fine or civil money penalty levied as a result of the survey finding.

Please submit your response(s) within 15 days of the date of this letter in accordance with 10 NYCRR 710.3(a). Please direct the additional information be sent directly to the undersigned at the Bureau of Nursing Home Licensure and Certification, New York State Department of Health, 875 Central Avenue, Albany, New York 12206.

Processing of your application by the Bureau of NH Licensure and Certification cannot be completed until the information is received and reviewed. You are encouraged to submit the response at your earliest opportunity.

If you have any questions on the information requested, please contact the undersigned at (518) 473-7285.

Sincerely,

Brian W. Morris

Brian W. Morris
Health Program Administrator 2

EXHIBIT 56

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

February 28, 2018

Ms. Deborah Lynch
Principal
Loeb & Troper LLP
655 Third Avenue
New York, New York 10017

Re: 161047-E
The Villages of Orleans Health and Rehabilitation Center
(Orleans County)
Transfer of 96.68% of ownership shares from the current sole member to ten (10) new members

Dear Ms. Lynch:

This letter is a follow-up communication on the above referenced Certificate of Need application.

As no information has been provided in response to my letter dated February 12, 2018, this project is deemed abandoned, pursuant to NYCRR Section 710.3 of Title 10 (Health Law) of the official compilation of Codes, Rules and Regulations of the State of New York.

If you have any questions, please contact the Bureau of Project Management at (518) 402-0911.

Sincerely,

Barbara DelCogliano
Deputy Director
Division of Planning and Licensure

BD/mrc

EXHIBIT 57

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

August 14, 2014

Deborah Lynch
Principal
Loeb & Troper LLP
655 Third Avenue
New York, New York 10017

Re: 141128 E
Comprehensive at Orleans, LLC
d/b/a The Villages of Orleans Health and Rehabilitation Center
Establish Comprehensive at Orleans, LLC as the new operator of The Villages of Orleans Health and Rehabilitation Center

Dear Ms. Lynch:

I am pleased to inform you that, based on action taken at its meeting on August 7, 2014, the Public Health and Health Planning Council proposes to approve the above application providing the contingencies set forth in the enclosed resolution are first satisfied. Pursuant to 10 NYCRR section 600.4, documentation to satisfy the contingencies imposed by the Council shall be submitted to the Center for Health Care Facility Planning, Licensure, and Finance as follows:

- Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the Contingencies Tab in NYSE-CON.

  Failure to meet the due date(s) could result in the project being abandoned as set forth in 10 NYCRR Section 710.10 (c) (1)

- Receive written approval from the Public Health and Health Planning Council Executive Secretary indicating satisfaction of the contingencies.

In addition to the contingencies, the proposed approval included the enclosed conditions. You are expected to comply with the conditions throughout the operation of this project, including any and all conditions pertaining to specified timeframes.

Before beginning any aspect of this project, you receive written approval from the Public Health and Health Planning Council indicating the satisfaction of all contingencies.

This letter should not be construed as approval to file, with the Secretary of State, a certificate of incorporation, a certificate of amendment to a certificate of incorporation, a restated certificate of incorporation, an application for authority, articles of organization or any amendments thereto, or any other legal documents. A separate Public Health and Health Planning Council approval letter will be issued, as necessary, for the filing of documents with the Secretary of State after all contingencies are satisfied.

Also, this letter should not be construed as approval of property or lease costs submitted in support of this application, nor is this letter an assurance or recommendation that property costs or lease amounts as specified in the application will be reimbursable.

If you have any questions concerning this letter, please contact the Bureau of Project Management at (518) 402-0911.

Sincerely,

Keith W. Servis
Deputy Director
Office of Primary Care and
Health Systems Management

Enclosures

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 7th day of August, 2014, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish Comprehensive at Orleans, LLC as the new operator of The Villages of Orleans Health and Rehabilitation Center, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY/APPLICANT:
141128 E	Comprehensive at Orleans, LLC d/b/a The Villages of Orleans Health and Rehabilitation Center

APPROVAL CONTINGENT UPON:

1. Submission of a loan commitment for the purchase price that is acceptable to the Department of Health. [BFA]
2. Submission of an executed lease agreement that is acceptable to the Department of Health. [BFA]
3. Submission of a copy of an executed Leaseback Agreement between the County of Orleans and the Orleans Health Facilities Corporation ("OHFC"), acceptable to the Department. [CSL]
4. Submission of a copy of an executed Purchase and Sale Agreement among the Orleans County Health Facilities Corporation ("OHFC"), the County of Orleans, and Comprehensive at Orleans, LLC, acceptable to the Department. [CSL]
5. Submission of a copy of the executed Articles of Organization of Telegraph Realty, LLC, acceptable to the Department. [CSL]
6. Submission of a copy of the executed Operating Agreement of Telegraph Realty, LLC, acceptable to the Department. [CSL]
7. Submission of a copy of an executed Escrow Agreement among Harris Beach, PLLC, Orleans County Health Facility Corporation, Comprehensive at Orleans, LLC, and Telegraph Realty, LLC must be provided. [CSL]
8. Submission of a copy of the applicant's executed Certificate of Amendment of the Articles of Organization of Comprehensive at Orleans LLC, acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within three years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

EXHIBIT 58

Public Health and Health Planning Council

Project # 141128-E

Comprehensive at Orleans, LLC d/b/a The Villages of Orleans Health and Rehabilitation Center

Program: **Residential Health Care Facility**
Purpose: **Establishment**

County: **Orleans**
Acknowledged: **March 31, 2014**

Executive Summary

Description

Comprehensive at Orleans, LLC d/b/a The Villages of Orleans Health and Rehabilitation Center, is seeking approval to become established as the new operator of the existing 120-bed, public county residential health care facility (RHCF) located at 14012 Route 31 in Albion. The sole member of Comprehensive at Orleans is Bernard Fuchs.

On March 8, 2013, the County entered into a lease agreement with the Orleans County Health Facilities Corporation (OCHFC), giving the latter a lease with an exclusive option to purchase the facility. OCHFC has entered into a purchase and sale agreement to sell the nursing facility to Comprehensive at Orleans, the proposed operator and Telegraph Realty, LLC, the real property purchaser. The County of Orleans entered into a Facility Transition Agreement with the proposed operator on February 6, 2014.

Since March of 2011, Bernard Fuchs has had a 6% membership interest in Hopkins Center for Rehabilitation & Healthcare a 288-bed RHCF located in Brooklyn, and a 25% membership interest in Bensonhurst Center for Rehab and Residential Care since January of 2012, a 200-bed RHCF located in Brooklyn.

DOH Recommendation

Contingent Approval

Need Summary

The Department of Health estimates that there will be a need for 360 RHCF beds in Orleans County by 2016. With an approved capacity of 310 beds, the County is expected to have a shortage of 50 beds. While this proposal will not affect existing capacity, it does involve the second largest of three residential health care facilities in Orleans County, representing one third of the projected need.

Program Summary

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application. The facility is in compliance with CMS 2013 sprinkler mandates.

Financial Summary

The purchase price for the operating assets and real property is $7,800,000. The purchase price will be paid by $1,560,000 in cash and a $6,240,000 mortgage at 5.50% over a 3-year term with a 25-year amortization via a bridge to HUD loan. Telegraph Realty, LLC has submitted an affidavit stating that they will fund the balloon payment, should acceptable financing not be available at the time the bridge loan comes due after the 3-year period and if they cannot obtain a HUD loan or fixed rate term loan.

There are no project costs associated with this proposal.

Budget:	Revenues:	$10,595,000
	Expenses:	$10,453,000
	Gain:	$142,000

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA recommendation for this project.

Office of Health Systems Management

Approval contingent upon:

1. Submission of a loan commitment for the purchase price that is acceptable to the Department of Health. [BFA]
2. Submission of an executed lease agreement that is acceptable to the Department of Health. [BFA]
3. Submission of a copy of an executed Leaseback Agreement between the County of Orleans and the Orleans Health Facilities Corporation ("OHFC"), acceptable to the Department. [CSL]
4. Submission of a copy of an executed Purchase and Sale Agreement among the Orleans County Health Facilities Corporation ("OHFC"), the County of Orleans, and Comprehensive at Orleans, LLC, acceptable to the Department. [CSL]
5. Submission of a copy of the executed Articles of Organization of Telegraph Realty, LLC, acceptable to the Department. [CSL]
6. Submission of a copy of the executed Operating Agreement of Telegraph Realty, LLC, acceptable to the Department. [CSL]
7. Submission of a copy of an executed Escrow Agreement among Harris Beach, PLLC, Orleans County Health Facility Corporation, Comprehensive at Orleans, LLC, and Telegraph Realty, LLC must be provided. [CSL]
8. Submission of a copy of the applicant's executed Certificate of Amendment of the Articles of Organization of Comprehensive at Orleans LLC, acceptable to the Department. [CSL]

Approval conditional upon:

1. The project must be completed within three years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Council Action Date

August 7, 2014

Need Analysis

Project Summary

Comprehensive at Orleans, an LLC owned solely by Mr. Bernhard Fuchs, is seeking approval for the complete transfer of ownership of The Villages of Orleans Health and Rehabilitation Center, of 14012 Route 31, Albion, NY, from Orleans County to the LLC. The Villages of Orleans Health and Rehabilitation Center will remain a 120 bed residential health care facility located in Orleans County. Mr. Fuchs currently has interests in two residential health care facilities, both in Kings County: Bensonhurst Center for Rehabilitation and Healthcare and Hopkins Center for Rehabilitation and Healthcare.

Analysis

The following table summarizes occupancy and Medicaid admissions rates at The Villages of Orleans Health and Rehabilitation Center over the last 3 years.

Year	2010	2011	2012
Occupancy	91.5%	93.5%	91.9%
Medicaid Admissions	22.8%	25.0%	25.6%

While occupancy rates are below the Department's 97% planning goal, they have been consistently above the County average. Medicaid admissions have also consistently exceeded the Department's 75% of County average minimum standard.

Conclusion

Upon approval of this proposal there will be no change to the RHCF capacity of Orleans County. However, the Department hopes that this project will allow the continued operation of The Village of Orleans Health and Rehabilitation Center, which provides necessary nursing home services to the residents of an underserved county. In light of the unmet need and the reasonable utilization and Medicaid admission rates of the facility, approval of this proposal is recommended.

Recommendation

From a need perspective, approval is recommended.

Program Analysis

Facility Information

	Existing	Proposed
Facility Name	The Villages of Orleans Health & Rehabilitation Center	Same
Address	14012 Route 31 Albion, NY 14411	Same
RHCF Capacity	120	Same
ADHC Program Capacity	N/A	Same
Type of Operator	County	Limited Liability Company
Class of Operator	Public	Proprietary
Operator	Orleans County Legislature	Comprehensive at Orleans, LLC d/b/a The Villages of Orleans Health & Rehabilitation Center Members: Bernard Fuchs 100.00%

Character and Competence - Background

Facilities Reviewed

Nursing Homes:

Hudson Pointe at Riverdale Center for Nursing and Rehabilitation	01/2006 to 08/2010
Hopkins Center for Rehabilitation and Healthcare	03/2011 to present
Bensonhurst Center for Rehabilitation and Healthcare	01/2012 to present

Individual Background Review

Bernard Fuchs is the CEO and Chief Investment Officer at Tiferes Investors LLC, an investment company located in Lawrence, New York. Mr. Fuchs discloses the following ownership interests in health facilities:

Hudson Pointe at Riverdale Center for Nursing and Rehabilitation	01/2006 to 08/2010
Hopkins Center for Rehabilitation and Healthcare	03/2011 to present
Bensonhurst Center for Rehabilitation and Healthcare	01/2012 to present

Character and Competence - Analysis

No negative information has been received concerning the character and competence of the above applicants identified as new members.

A review of Hopkins Center for Rehabilitation and Healthcare for the period identified above reveals the following:

- The facility was fined $4,000 pursuant to Stipulation and Order NH-12-037 issued August 24, 2012 for surveillance findings on April 11, 2011. Deficiencies were found under 10 NYCRR 415.12(h)(1)(2) – Quality of Care: Accidents; and 10 NYCRR 415.26 – Administration.

A review of operations for Hopkins Center for Rehabilitation and Healthcare for the periods identified above, results in a conclusion of substantially consistent high level of care since there were no repeat enforcements.

A review of operations for Hudson Pointe at Riverdale Center for Nursing and Rehabilitation, and Bensonhurst Center for Rehabilitation and Healthcare for the periods identified above, results in a conclusion of substantially consistent high level of care since there were no enforcements.

Project Review

No changes in the program or physical environment are proposed in this application. The facility is in compliance with CMS 2013 sprinkler mandates.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Facility Transition Agreement

On February 6, 2014, County of Orleans and Comprehensive at Orleans, LLC entered into a transition agreement with the acknowledgement of Orleans County Health Facilities Corporation (OCHFC), a local development corporation. Previously, The County of Orleans and OCHFC entered into a lease agreement with exclusive option to purchase and acquire the facility assets. The County of Orleans has a leaseback agreement whereas the County leases the Facility Assets back from OCHFC for operating purposes.

Purchase and Sale Agreement

The change in ownership will be effectuated in accordance with an executed purchase and sale agreement, the terms of which are summarized below:

Date:	February 6, 2014
Seller:	Orleans County Health Facilities Corporation
Purchaser :	Comprehensive at Orleans, LLC, the operator and Telegraph Realty, LLC, the real property purchaser
Purchased Assets:	The real property and all assets used in operation of the facility. Facilities; equipment; supplies and inventory; prepaid expenses; documents and records; assignable leases, contracts, licenses and permits; telephone numbers, fax numbers and all logos; resident trust funds; deposits; accounts and notes receivable; cash, deposits and cash equivalents;
Excluded Assets:	Any security, vendor, utility or other deposits with any Governmental Entity; any refunds, debtor claims, third-party retroactive adjustments and related documents prior to closing, and personal property of residents.
Assumed Liabilities:	Those associated with purchased assets.
Purchase Price:	$7,800,000 for the operating interest and real property.
Payment of Purchase Price:	A $780,000 down payment held in escrow with the balance at closing.

The real property has been purchased by Telegraph Realty, LLC for $7.800,000, which is owned by Ephram Lahasky, David Gast and Josh Farkovits, who are not associated with the proposed member of the operations. Telegraph will transfer the operations to Comprehensive at Orleans, LLC.

The proposed members have submitted an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring interest, without releasing the transferor of its liability and responsibility.

Lease Agreement

Facility occupancy is subject to a draft lease agreement, the terms of which are summarized as follows:

Premises:	A 120-bed RHCF located at 14012 Route 31, Albion
Lessor:	Telegraph Realty, LLC
Lessee:	Comprehensive at Orleans, LLC
Terms:	10 years commencing on the execution of the lease
Rental:	Base rent equal to the debt service payments of the mortgage covering the premises. $459,829 per year plus $600,000 per year.
Provisions:	Tenant is responsible for taxes, insurance, utilities and maintenance

The lease arrangement is a non-arm's lease agreement. The applicant has submitted an affidavit attesting to the relationship between landlord and tenant in that members of each company have previous business relationships involving real estate transactions in Beaver, Pennsylvania.

Operating Budget

Following is a summary of the submitted operating budget for the RHCF, presented in 2014 dollars, for the first year subsequent to change in ownership:

Revenues:	
Medicaid	$7,097,000
Medicare	1,934,000
Private Pay	1,564,000
Total Revenues	$10,595,000
Expenses:	
Operating	$9,199,000
Capital	1,254,000
Total Expenses	$10,453,000
Net Income	$142,000
Utilization: (patient days)	41,612
Occupancy	95.0%

The following is noted with respect to the submitted RHCF operating budget:

- Expenses include lease rental.
- Medicaid revenues include assessment revenues.
- Medicaid rates are based on 2014 Medicaid pricing rates with no trend.
- Medicare and Private Rates are based on the experience of the County.
- Overall utilization is projected at 95.0%, while utilization by payor source is expected as follows:
  - Medicaid 80.50%
  - Medicare 9.13%
  - Private Pay 10.37%
- Breakeven occupancy is projected at 93.73%.

Capability and Feasibility

The purchase price for the realty and operations will be financed by a loan of $6,240,000 at an interest rate of 5.5% for 10 years, with a 25-year amortization with the remaining $1,560,000 from the members of Telegraph Realty, LLC, who will then transfer the operations to the proposed member of Comprehensive at Orleans, LLC. BFA Attachment B is the net worth statement of the members of Telegraph Realty, LLC, which shows sufficient equity. A Letter of Interest has been submitted by HHC Finance. A bridge-to-HUD financing loan has been proposed for the acquisition of the assets, which includes the estimated bridge fees, HUD application fees, debt reserves, repairs and bridge closing costs, and anticipates a HUD loan approval within two to three years.

Telegraph Realty, LLC has submitted an affidavit stating that they will fund the balloon payment, should acceptable financing not be available at the time the bridge loan comes due after the 3 year period, and if they cannot obtain a HUD loan or fixed rate term loan.

Working capital requirements are estimated at $1,742,167 based on two months of the first year expenses, which will be satisfied from the proposed member's equity. BFA Attachment A is the net worth of proposed member, which shows sufficient equity.

The submitted budget indicates that a net income of $142,000 would be maintained during the first year following change in ownership. DOH staff has reviewed the difference between the current 2012 certified net operating loss of $2,825,048, as shown on BFA Attachment D, and the first year budgeted net income of $142,000 and has concluded that the difference is due to the reduction in employee fringe benefits of $1,702,000, staffing decreases of $241,000 without interruption of care and increased reimbursement rates of $1,335,000, as shown on BFA Attachment I. The facility will no longer participate in the County benefit plan. BFA Attachment G is the budget sensitivity analysis based on April 30, 2014 current utilization of the facility, which shows the budgeted revenues would decrease by $125,872 resulting in a net income in year one of $17,128. The increased utilization has occurred for the last 6 months. The increased Medicaid rate is based on current acuity levels at the RHCF. BFA Attachment C is the pro-forma balance sheet of The Villages of Orleans Health and Rehabilitation Center, which indicates positive member equity of $1,742,000 as of the first day of operations. The budget appears reasonable.

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

As shown on BFA Attachment D, the facility maintained positive working capital and positive net assets and an average net loss from operations of $2,698,001 for the period shown between 2011-2013, and a net operating loss of $892,192 as of April 30, 2014. The county cannot maintain its current operation due to re-occurring losses from year to year and has therefore decided to sell the facility to a new operator.

BFA Attachments E and F, Financial Summary of the proposed member affiliated RHCFs, shows the facilities have maintained positive income from operations for the periods shown. Bensonhurst Center for Rehabilitation and Hopkins Center for Rehabilitation had negative working capital in 2012 and 2013, respectively, due to organization and financing costs under new ownership.

Based on the preceding, and subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Net Worth of Proposed Members
BFA Attachment B	Net Worth of property members- Telegraph Realty , LLC
BFA Attachment C	Pro-forma Balance Sheet,
BFA Attachment D	Financial Summary, 2011- April 30,2014
BFA Attachment E	Financial Summary of Hopkins Center for Rehabilitation & Healthcare
BFA Attachment F	Financial Summary of Bensonhurst Center for Rehab & Residential Care
BFA Attachment G	Budget Sensitivity Analysis
BFA Attachment H	Amortization Table for Mortgage Payment
BFA Attachment I	Calculation of increased Medicaid reimbursement rates

EXHIBIT 59

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue		RHCF	Revenue - Other	Total
		0463	0160	0161
Analysis of Total Operating Revenue				
Medicaid Net Revenue				
A. Social Services	011	6,440,743		6,440,743
B. Managed Care Provider	025			
C. Other Services	012			
TOTAL MEDICAID NET REVENUE	001	6,440,743		6,440,743
Medicare Net Revenue				
A. Part A - All Income	002	542,708		542,708
B Part B - Income	003			
C. Part B - Final Settlement	004			
D. Managed Care Provider	026			
TOTAL MEDICARE NET REVENUE	013	542,708		542,708
Private Patient Revenue	005	2,999,544		2,999,544
Other Net Patient Revenue	006			
TOTAL NET PATIENT REVENUE	010	9,982,995		9,982,995
All Other Operating Revenue*	015	117,658		117,658
TOTAL OPERATING REVENUE	020	10,100,653		10,100,653

*Line 0015 Column 00160 would be used for reporting revenue for all other operating revenue centers.

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue (continued)		Blue Cross	Travelers	Other
		0243	0244	0245
Part B Cash Receipts By Intermediary				
For Report Year	021			
For Prior Year	022			
All Other Years	023			
TOTAL	030			

Schedule 9 - Property Expenses (All Property Expenses Must be Reported on This Schedule)		Amount	Cost Center Line No. Affected
		0270	0271
Building/Fixed Equipment:			
Depreciation - Owned Assets	001		001
Depreciation - Captitalized Assets	002		001
Interest - Mortgage(s)	003		003
Interest - Capitalized Leases	004		003
Rent	005	1,852,506	001
Property Insurance	006	15,937	005
Boiler Insurance	007		
	008		
	009		
	010		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	011		
Interest - Mortgages	012		
Amortization	013		
TOTAL (Lines 001 thru 013)	015	1,868,443	
Land/Leasehold Improvements:			
Depreciation - Owned Assets	016		001
Depreciation - Capitalized Leases	017		001
Amortization	018	41,297	001
Interest - Owned Assets	019		003
Interest - Capitalized Leases	020		003
Rent	021		001
	022		
	025		
	026		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	027		
Interest - Mortgages	028		
Amortization	029		
TOTAL (Lines 016 thru 022 + 025 thru 029)	031	41,297	
Moveable Equipment:			
Depreciation - Owned Assets	032	37,430	002
Depreciation - Capitalized Leases	033	21,867	002
Interest - Mortgage(s)	034		003
Interest - Capitalized Leases	035	10,038	003
Interest - Other	036		
Equipment Rent A	037		
Equipment Rent B	038		
Equipment Rent C	039	8,603	043
Equipment Rent D	040		
Equipment Rent E	041	48,631	004
Equipment Rent F	042		
Equipment Rent G	043		
Equipment Rent H	044		
Equipment Rent I	045		
Equipment Rent J	046		
Equipment Rent K	047		
Equipment Rent L	048		
Equipment Rent M	049		
Equipment Rent N	050		
Equipment Rent O	051		
Equipment Rent P	052		
Equipment Rent Q	053		
Equipment Rent R	054		
Equipment Rent S	055		
Equipment Rent T	056		
Equipment Rent U	057		
Equipment Rent V	058		
Equipment Rent W	059		
Equipment Rent X	060		
Equipment Rent Y	061		
Equipment Rent Z	062		
Computer Equipment Rent	063	58,871	004
TOTAL Rental (Lines 37 thru 63)	096	116,105	
Auto Insurance	064	1,519	006
Rent: All Capitalized Leases (Sch. 9A)	065	62,490	006
	067		
TOTAL (Lines 032 thru 067)	070	249,449	
Other:			
Sales Tax	071	90,153	005
Real Estate Taxes	023	57,475	006
Payments in lieu of Taxes	094		006
Occupancy Taxes	024		006
Mortgage Insurance Premium	072		
Fees & Charges: 28A Fees	073	553	005
Fees: Outside PRI Assessor	074		
Other Fees (Specify):			
	075		
Amortization - Mortgage Expense	076		
Amortization - Organization Expense	077	3,016	005
Amortization - Legal Expense	078		005
Nurse Aide Training Costs	079	125	005
Nurse Aide Testing Costs	080	1,440	005
NYS Revenue Assessment	081	460,628	005
Bad Debts	082	199,660	005
Telephone Equipment - Depreciation	091		
Telephone Equipment - Interest	092		
Telephone Equipment - Rental	093		
	083		
	084		
	085		

Exhibit H Statement of Functional Expenses		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Nonrevenue Support Services:												
Depreciation Leases & Rental	001							1,893,803				1,893,803
Depreciation, Major Movable Equip.	002							59,297				59,297
Interest on Capital Debt	003								10,038			10,038
Fiscal Services	004				72,553	14,437	39,096	107,502	8,464			242,052
Administrative Services	005	422,828		117,985	190,108			3,016	911,605			1,645,542
Plant Operation & Maint.	006	58,937		16,426		9,208	29,917		263,332			377,820
Grounds	007					402	170					572
Security	008				16,443	614	678					17,735
Laundry and Linen	009	21,988		6,250		48,740	34,022					111,000
Housekeeping	010	273,153		76,764		29,696	78,940					458,553
Patient Food Service	011	317,791		88,546		305,281	180,022					891,640
Cafeteria	012											
Nursing Administration	013	179,422		49,748								229,170
Activities Program	014	85,490		23,914	6,452	1,170	8,032					125,058
Nonphysician Education	015											
Medical Education	016											
Medical Director's Office	017		26,609									26,609
Housing	018											
Medical Records	019	34,420		9,487		147						44,054
Utilization Review	020											
Social Service	021	94,570		26,095	7,625							128,290
Transportation	022											
TOTAL (Lines 001 thru 022)	030	1,488,599	26,609	415,215	293,181	409,695	370,877	2,063,618	1,193,439			6,261,233
Ancillary Services												
Laboratory Services	031				3,521	71						3,592
Electrocardiology	032											
Electroencephalogy	033											
Radiology	034					7,824						7,824
Inhalation Therapy	035					126						126
Podiatry	036											
Dental	037				21,600							21,600
Psychiatric	038				7,625							7,625
Physical Therapy	039				21,932	1,958	292,072					315,962
Occupational Therapy	040						265,539					265,539
Speech/Hearing Therapy	041						52,059					52,059
Pharmacy	042					126,250						126,250
Central Service Supply	043				383	57,003	7,686	8,603				73,675
Medical Staff Services	044		85									85

Exhibit H Statement of Functional Expenses (continued)		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Ancillary Other (specify below):												
	045											
	046											
	047											
TOTAL (Lines 031 thru 047)	050		85		55,061	193,232	617,356	8,603				874,337
Program Services												
Res. Health Care Fac.	051	963,009		267,904			1,933,830					3,164,743
Adult Care Facility	053											
I.C.F. Mental Retardation	054											
Independent Living	055											
Outpatient Clinics	057											
Home Health Care	059											
Homemaker-Services	060											
Meals on Wheels	061											
Research	062											
Physicians' Office & Other Rentals	063											
Gift Shop	064											
Public Restaurant	065											
Fund Raising	066											
Barber & Beauty Shops	067											
Sold Services	068											
Other	069											
TOTAL (Lines 051 thru 089)	090	963,009		267,904			1,933,830					3,164,743
GRAND TOTAL (Lines 030 + 050 + 090)	099	2,451,608	26,694	683,119	348,242	602,927	2,922,063	2,072,221	1,193,439			10,300,313

Schedule P Staff Turnover RHCF		Total number of employees									
		1-Jan	31-Mar	30-Jun	30-Sep	31-Dec	Full Time as of 12/31	Part Time as of 12/31	Employees retained as of 12/31, who were employed on 1/1	Employees Hired (Year)	Employees Terminated (Year)
		0770	0771	0772	0773	0774	0775	0776	0777	0778	0779
NON-CONTRACT STAFF											
RN Director of Services	001	2	2	2	1	1	1		1		1
Nurses with Administrative Duties	002	2	2	2	2	2	2		2		
Registered Nurses	003	6	6	6	7	7	8	1	3	7	4
Licensed Practical/License Vocational Nurses	004	24	23	22	27	27	21	7	15	14	9
Certified Nurse Aides	005										
Total Lines 1 - 5 Employees	006	34	33	32	37	37	32	8	21	21	14
Occupational Therapists	007										
Occupational Therapy Assistants	008										
Occupational Therapy Aides	009										
Physical Therapists	010										
Physical Therapists Assistants	011										
Physical Therapy Aides	012										
Speech/Language Pathologist	013										
Respiratory Therapists	014										
Qualified Social Workers	015	2	2	3	2	1	1			1	2
Other Social Services	016										
Total Lines 7 - 16 Employees	017	2	2	3	2	1	1			1	2
Total Lines 6 and 17	018	36	35	35	39	38	33	8	21	22	16
CONTRACT STAFF											
RN Director of Services	019										
Nurses with Administrative Duties	020										
Registered Nurses	021			1	1					1	1
Licensed Practical/License Vocational Nurses	022			1	3					10	10
Certified Nurse Aides	023	56	60	61	70	66	31	32	39	42	36
Total Lines 19 - 23 Employees	024	56	60	63	74	66	31	32	39	53	47
Occupational Therapists	025	2	1	3	2	2	2		2	3	3
Occupational Therapy Assistants	026										
Occupational Therapy Aides	027	3	3	3	4	3	2	1	2		3
Physical Therapists	028	4	3	1	2	2	2		1	4	4
Physical Therapists Assistants	029										
Physical Therapy Aides	030	6	3	3	4	3	1	2	2		5
Speech/Language Pathologist	031			2	1	1		1			1
Respiratory Therapists	032										
Qualified Social Workers	033										
Other Social Services	034										
Total Lines 25 - 34 Employees	035	15	10	12	13	11	7	4	7	7	16
Total Lines 24 and 35	036	71	70	75	87	77	38	36	46	60	63

Schedule 4 - Salaries And Wages		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
NonRevenue Support Services:										
Fiscal Services	004									
Administration Services	005	156,127					266,701			422,828
Plant Operation & Maint.	006	43,927						15,010		58,937
Grounds	007									
Security	008									
Laundry and Linen	009							21,988		21,988
Housekeeping	010							273,153		273,153
Patient Food Service	011		76,415					241,376		317,791
Cafeteria	012									
Nursing Administration	013	127,664		51,758						179,422
Activities Program	014	18,277				67,213				85,490
NonPhysician Education	015									
Medical Education	016									
Medical Director's Office	017									
Housing	018									
Medical Records	019		34,420							34,420
Utilization Review	020									
Social Services	021					89,157	5,413			94,570
Transportation	022									
TOTAL	030	345,995	110,835	51,758		156,370	272,114	551,527		1,488,599
Ancillary Services:										
Laboratory Services	031									
Electrocardiology	032									
Electroencephalogy	033									
Radiology	034									
Inhalation Therapy	035									
Podiatry	036									
Dental	037									
Psychiatric	038									
Physical Therapy	039									
Occupational Therapy	040									
Speech/Hearing Therapy	041									
Pharmacy	042									
Central Service Supply	043									
Medical Staff Services	044									

Schedule 4 - Salaries And Wages (continued)		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
Ancillary Services - Other (specify below):										
	045									
	046									
	047									
TOTAL (Lines 031 thru 047)	050									
Program Services:										
Res. Health Care Fac.	051			186,919	776,090					963,009
Adult Care Facility	053									
I.C.F. Mental Retardation	054									
Independent Living	055									
Outpatient Clinics	057									
Home Health Care	059									
Homemaker-Services	060									
Meals on Wheels	061									
Research	062									
Physicians' Office & Other Rentals	063									
Gift Shop	064									
Public Restaurant	065									
Fund Raising	066									
Barber & Beauty Shops	067									
Sold Services	068									
Other	069									
TOTAL (Lines 051 thru 089)	090			186,919	776,090					963,009
GRAND TOTAL (Lines 030 + 050 + 090)	099	345,995	110,835	238,677	776,090	156,370	272,114	551,527		2,451,608

Schedule 5 - Full Time Equivalents & Hours Paid		Number of Wks for Calculation
		0140
IMPORTANT:		
This box must be completed. Enter on line 001 the number of weeks used		
in the calculation of the columns "Hours Paid" on Schedule 5 and "Hours Worked"		
on Schedule 5A. A typical entry would be 52 wks. If the data is not for		
52 wks, enter the number of weeks included in the calculation.	001	52

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
NonRevenue Support Services:																		
Fiscal Services	004																	
Administration Services	005	1.90	3,701									3.43	6,691					5.33
Plant Operation & Maint.	006	0.84	1,633											0.59	1,156			1.43
Grounds	007																	
Security	008																	
Laundry and Linen	009													0.89	1,742			0.89
Housekeeping	010													10.53	20,534			10.53
Patient Food Service	011			2.54	4,957									9.75	19,010			12.29
Cafeteria	012																	
Nursing Administration	013	1.84	3,596			0.87	1,701											2.71
Activities Program	014	0.57	1,104							2.75	5,357							3.32
NonPhysician Education	015																	
Medical Education	016																	
Medical Director's Office	017																	
Housing	018																	
Medical Records	019			1.04	2,033													1.04
Utilization Review	020																	
Social Services	021									2.16	4,215	0.15	296					2.31
Transportation	022																	
TOTAL	030	5.15	10,034	3.58	6,990	0.87	1,701			4.91	9,572	3.58	6,987	21.76	42,442			39.85
Laboratory Services	031																	
Electrocardiology	032																	
Electroencephalogy	033																	
Radiology	034																	
Inhalation Therapy	035																	
Podiatry	036																	
Dental	037																	
Psychiatric	038																	
Physical Therapy	039																	
Occupational Therapy	040																	
Speech/Hearing Therapy	041																	
Pharmacy	042																	
Central Service Supply	043																	
Medical Staff Services	044																	

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
Ancillary Services - Other																		
(specify below):																		
	045																	
	046																	
	047																	
TOTAL (Lines 031 thru 047)	050																	
Res. Health Care Fac.	051					3.23	6,305	19.89	38,790									23.12
Adult Care Facility	053																	
I.C.F. Mental Retardation	054																	
Independent Living	055																	
Outpatient Clinics	057																	
Home Health Care	059																	
Homemaker-Services	060																	
Meals on Wheels	061																	
Research	062																	
Physicians' Office & Other	063																	
Gift Shop	064																	
Public Restaurant	065																	
Fund Raising	066																	
Barber & Beauty Shops	067																	
Sold Services	068																	
Other	069																	
TOTAL (Lines 051 thru 089)	090					3.23	6,305	19.89	38,790									23.12
GRAND TOTAL																		
(Lines 030 + 050 + 090)	099	5.15	10,034	3.58	6,990	4.10	8,006	19.89	38,790	4.91	9,572	3.58	6,987	21.76	42,442			62.97

EXHIBIT 60

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue		RHCF	Revenue - Other	Total
		0463	0160	0161
Analysis of Total Operating Revenue				
Medicaid Net Revenue				
A. Social Services	011	6,344,156		6,344,156
B. Managed Care Provider	025			
C. Other Services	012			
TOTAL MEDICAID NET REVENUE	001	6,344,156		6,344,156
Medicare Net Revenue				
A. Part A - All Income	002	874,496		874,496
B Part B - Income	003	129,095		129,095
C. Part B - Final Settlement	004			
D. Managed Care Provider	026			
TOTAL MEDICARE NET REVENUE	013	1,003,591		1,003,591
Private Patient Revenue	005	3,695,785		3,695,785
Other Net Patient Revenue	006			
TOTAL NET PATIENT REVENUE	010	11,043,532		11,043,532
All Other Operating Revenue*	015	233,761		233,761
TOTAL OPERATING REVENUE	020	11,277,293		11,277,293

*Line 0015 Column 00160 would be used for reporting revenue for all other operating revenue centers.

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue (continued)		Blue Cross	Travelers	Other
		0243	0244	0245
Part B Cash Receipts By Intermediary				
For Report Year	021			69,660
For Prior Year	022			50,632
All Other Years	023			
TOTAL	030			120,292

Schedule 9 - Property Expenses (All Property Expenses Must be Reported on This Schedule)		Amount	Cost Center Line No. Affected
		0270	0271
Building/Fixed Equipment:			
Depreciation - Owned Assets	001		001
Depreciation - Captitalized Assets	002		001
Interest - Mortgage(s)	003		003
Interest - Capitalized Leases	004		003
Rent	005	2,097,992	001
Property Insurance	006	16,149	005
Boiler Insurance	007		
	008		
	009		
	010		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	011		
Interest - Mortgages	012		
Amortization	013		
TOTAL (Lines 001 thru 013)	015	2,114,141	
Land/Leasehold Improvements:			
Depreciation - Owned Assets	016		001
Depreciation - Capitalized Leases	017		001
Amortization	018	85,561	001
Interest - Owned Assets	019		003
Interest - Capitalized Leases	020		003
Rent	021		001
	022		
	025		
	026		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	027		
Interest - Mortgages	028		
Amortization	029		
TOTAL (Lines 016 thru 022 + 025 thru 029)	031	85,561	
Moveable Equipment:			
Depreciation - Owned Assets	032	76,333	002
Depreciation - Capitalized Leases	033	43,733	002
Interest - Mortgage(s)	034		003
Interest - Capitalized Leases	035	7,774	003
Interest - Other	036		
Equipment Rent A	037		
Equipment Rent B	038		
Equipment Rent C	039	21,365	043
Equipment Rent D	040		
Equipment Rent E	041	18,177	004
Equipment Rent F	042		
Equipment Rent G	043		
Equipment Rent H	044		
Equipment Rent I	045	2,628	011
Equipment Rent J	046		
Equipment Rent K	047		
Equipment Rent L	048		
Equipment Rent M	049		
Equipment Rent N	050		
Equipment Rent O	051		
Equipment Rent P	052		
Equipment Rent Q	053		
Equipment Rent R	054		
Equipment Rent S	055		
Equipment Rent T	056		
Equipment Rent U	057		
Equipment Rent V	058		
Equipment Rent W	059		
Equipment Rent X	060		
Equipment Rent Y	061		
Equipment Rent Z	062		
Computer Equipment Rent	063	45,671	004
TOTAL Rental (Lines 37 thru 63)	096	87,841	
Auto Insurance	064	1,525	006
Rent: All Capitalized Leases (Sch. 9A)	065	79,953	006
	067		
TOTAL (Lines 032 thru 067)	070	297,159	
Other:			
Sales Tax	071	22,534	005
Real Estate Taxes	023	197,999	006
Payments in lieu of Taxes	094		006
Occupancy Taxes	024		006
Mortgage Insurance Premium	072		
Fees & Charges: 28A Fees	073		005
Fees: Outside PRI Assessor	074		
Other Fees (Specify):			
	075		
Amortization - Mortgage Expense	076		
Amortization - Organization Expense	077	10,590	005
Amortization - Legal Expense	078		005
Nurse Aide Training Costs	079	255	005
Nurse Aide Testing Costs	080	1,400	005
NYS Revenue Assessment	081	524,514	005
Bad Debts	082		005
Telephone Equipment - Depreciation	091		
Telephone Equipment - Interest	092		
Telephone Equipment - Rental	093		
	083		
	084		
	085		

Exhibit H Statement of Functional Expenses		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Nonrevenue Support Services:												
Depreciation Leases & Rental	001							2,183,553				2,183,553
Depreciation, Major Movable Equip.	002							120,066				120,066
Interest on Capital Debt	003								7,774			7,774
Fiscal Services	004				79,600	9,962	60,930	63,848	4,802			219,142
Administrative Services	005	309,232		92,620	263,417			10,590	727,430			1,403,289
Plant Operation & Maint.	006	67,259		15,737		14,885	57,842		436,202			591,925
Grounds	007					1,438	610					2,048
Security	008				9,469	718	1,224					11,411
Laundry and Linen	009	27,528		6,883		45,829	692					80,932
Housekeeping	010	330,945		81,495		32,470	1,330					446,240
Patient Food Service	011	396,534		95,252		283,463	413	2,628				778,290
Cafeteria	012											
Nursing Administration	013	139,092		33,896								172,988
Activities Program	014	68,950		16,971	875	2,090	9,023					97,909
Nonphysician Education	015											
Medical Education	016											
Medical Director's Office	017		24,009									24,009
Housing	018											
Medical Records	019	42,554		11,141		197						53,892
Utilization Review	020											
Social Service	021	123,701		29,801	3,684		500					157,686
Transportation	022											
TOTAL (Lines 001 thru 022)	030	1,505,795	24,009	383,796	357,045	391,052	132,564	2,380,685	1,176,208			6,351,154
Ancillary Services												
Laboratory Services	031				5,380							5,380
Electrocardiology	032											
Electroencephalogy	033											
Radiology	034					16,765						16,765
Inhalation Therapy	035											
Podiatry	036											
Dental	037				21,600							21,600
Psychiatric	038				8,125							8,125
Physical Therapy	039				15,000	1,578	379,858					396,436
Occupational Therapy	040						315,146					315,146
Speech/Hearing Therapy	041						123,054					123,054
Pharmacy	042				212	145,690						145,902
Central Service Supply	043					78,035	1,008	21,365				100,408
Medical Staff Services	044											

Exhibit H Statement of Functional Expenses (continued)		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Ancillary Other (specify below):												
	045											
	046											
	047											
TOTAL (Lines 031 thru 047)	050				50,317	242,068	819,066	21,365				1,132,816
Program Services												
Res. Health Care Fac.	051	1,018,540		244,466			2,223,045					3,486,051
Adult Care Facility	053											
I.C.F. Mental Retardation	054											
Independent Living	055											
Outpatient Clinics	057											
Home Health Care	059											
Homemaker-Services	060											
Meals on Wheels	061											
Research	062											
Physicians' Office & Other Rentals	063											
Gift Shop	064											
Public Restaurant	065											
Fund Raising	066											
Barber & Beauty Shops	067											
Sold Services	068											
Other	069											
TOTAL (Lines 051 thru 089)	090	1,018,540		244,466			2,223,045					3,486,051
GRAND TOTAL (Lines 030 + 050 + 090)	099	2,524,335	24,009	628,262	407,362	633,120	3,174,675	2,402,050	1,176,208			10,970,021

Schedule P Staff Turnover RHCF		Total number of employees									
		1-Jan	31-Mar	30-Jun	30-Sep	31-Dec	Full Time as of 12/31	Part Time as of 12/31	Employees retained as of 12/31, who were employed on 1/1	Employees Hired (Year)	Employees Terminated (Year)
		0770	0771	0772	0773	0774	0775	0776	0777	0778	0779
NON-CONTRACT STAFF											
RN Director of Services	001	2	2	2	2	2	2		2		
Nurses with Administrative Duties	002	1	2	2	2	2	2		1	2	1
Registered Nurses	003	3	3	2	2	1	1			4	6
Licensed Practical/License Vocational Nurses	004	18	18	22	23	21	15	5	13	20	17
Certified Nurse Aides	005	35	41	38	40	42	18	20	31	19	10
Total Lines 1 - 5 Employees	006	59	66	66	69	68	38	25	47	45	34
Occupational Therapists	007										
Occupational Therapy Assistants	008										
Occupational Therapy Aides	009										
Physical Therapists	010										
Physical Therapists Assistants	011										
Physical Therapy Aides	012										
Speech/Language Pathologist	013										
Respiratory Therapists	014										
Qualified Social Workers	015	2	2	2	2	2	2		2		
Other Social Services	016										
Total Lines 7 - 16 Employees	017	2	2	2	2	2	2		2		
Total Lines 6 and 17	018	61	68	68	71	70	40	25	49	45	34
CONTRACT STAFF											
RN Director of Services	019										
Nurses with Administrative Duties	020										
Registered Nurses	021										
Licensed Practical/License Vocational Nurses	022	23	23	27	30	34			23	11	
Certified Nurse Aides	023	75	71	79	82	83			62	37	29
Total Lines 19 - 23 Employees	024	98	94	106	112	117			85	48	29
Occupational Therapists	025	2	3	6	8	9			2	7	
Occupational Therapy Assistants	026	2	4	4	4	4			2	2	
Occupational Therapy Aides	027										
Physical Therapists	028	5	7	8	9	10			5	5	
Physical Therapists Assistants	029	3	3	6	10	9			3	7	1
Physical Therapy Aides	030										
Speech/Language Pathologist	031		1	2	2	2				2	
Respiratory Therapists	032										
Qualified Social Workers	033										
Other Social Services	034										
Total Lines 25 - 34 Employees	035	12	18	26	33	34			12	23	1
Total Lines 24 and 35	036	110	112	132	145	151			97	71	30

Schedule 4 - Salaries And Wages		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
NonRevenue Support Services:										
Fiscal Services	004									
Administration Services	005	179,488					129,744			309,232
Plant Operation & Maint.	006	57,345						9,914		67,259
Grounds	007									
Security	008									
Laundry and Linen	009							27,528		27,528
Housekeeping	010	52,175						278,770		330,945
Patient Food Service	011	52,113	117,903					226,518		396,534
Cafeteria	012									
Nursing Administration	013	75,922		63,170						139,092
Activities Program	014					68,950				68,950
NonPhysician Education	015									
Medical Education	016									
Medical Director's Office	017									
Housing	018									
Medical Records	019		42,554							42,554
Utilization Review	020									
Social Services	021					83,259	40,442			123,701
Transportation	022									
TOTAL	030	417,043	160,457	63,170		152,209	170,186	542,730		1,505,795
Ancillary Services:										
Laboratory Services	031									
Electrocardiology	032									
Electroencephalogy	033									
Radiology	034									
Inhalation Therapy	035									
Podiatry	036									
Dental	037									
Psychiatric	038									
Physical Therapy	039									
Occupational Therapy	040									
Speech/Hearing Therapy	041									
Pharmacy	042									
Central Service Supply	043									
Medical Staff Services	044									

Schedule 4 - Salaries And Wages (continued)		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
Ancillary Services - Other (specify below):										
	045									
	046									
	047									
TOTAL (Lines 031 thru 047)	050									
Program Services:										
Res. Health Care Fac.	051			268,347	703,211	46,982				1,018,540
Adult Care Facility	053									
I.C.F. Mental Retardation	054									
Independent Living	055									
Outpatient Clinics	057									
Home Health Care	059									
Homemaker-Services	060									
Meals on Wheels	061									
Research	062									
Physicians' Office & Other Rentals	063									
Gift Shop	064									
Public Restaurant	065									
Fund Raising	066									
Barber & Beauty Shops	067									
Sold Services	068									
Other	069									
TOTAL (Lines 051 thru 089)	090			268,347	703,211	46,982				1,018,540
GRAND TOTAL (Lines 030 + 050 + 090)	099	417,043	160,457	331,517	703,211	199,191	170,186	542,730		2,524,335

Schedule 5 - Full Time Equivalents & Hours Paid		Number of Wks for Calculation
		0140
IMPORTANT:		
This box must be completed. Enter on line 001 the number of weeks used		
in the calculation of the columns "Hours Paid" on Schedule 5 and "Hours Worked"		
on Schedule 5A. A typical entry would be 52 wks. If the data is not for		
52 wks, enter the number of weeks included in the calculation.	001	52

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
NonRevenue Support Services:																		
Fiscal Services	004																	
Administration Services	005	2.79	5,432									1.45	2,831					4.24
Plant Operation & Maint.	006	1.07	2,080											0.40	778			1.47
Grounds	007																	
Security	008																	
Laundry and Linen	009													1.19	2,324			1.19
Housekeeping	010	1.03	2,000											11.19	21,815			12.22
Patient Food Service	011	1.03	2,016	3.44	6,716									9.88	19,260			14.35
Cafeteria	012																	
Nursing Administration	013	1.07	2,095			1.05	2,050											2.12
Activities Program	014									2.95	5,755							2.95
NonPhysician Education	015																	
Medical Education	016																	
Medical Director's Office	017																	
Housing	018																	
Medical Records	019			1.17	2,287													1.17
Utilization Review	020																	
Social Services	021									1.94	3,782	1.06	2,064					3.00
Transportation	022																	
TOTAL	030	6.99	13,623	4.61	9,003	1.05	2,050			4.89	9,537	2.51	4,895	22.66	44,177			42.71
Laboratory Services	031																	
Electrocardiology	032																	
Electroencephalogy	033																	
Radiology	034																	
Inhalation Therapy	035																	
Podiatry	036																	
Dental	037																	
Psychiatric	038																	
Physical Therapy	039																	
Occupational Therapy	040																	
Speech/Hearing Therapy	041																	
Pharmacy	042																	
Central Service Supply	043																	
Medical Staff Services	044																	

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
Ancillary Services - Other																		
(specify below):																		
	045																	
	046																	
	047																	
TOTAL (Lines 031 thru 047)	050																	
Res. Health Care Fac.	051					4.44	8,667	18.20	35,488	0.01	24							22.65
Adult Care Facility	053																	
I.C.F. Mental Retardation	054																	
Independent Living	055																	
Outpatient Clinics	057																	
Home Health Care	059																	
Homemaker-Services	060																	
Meals on Wheels	061																	
Research	062																	
Physicians' Office & Other	063																	
Gift Shop	064																	
Public Restaurant	065																	
Fund Raising	066																	
Barber & Beauty Shops	067																	
Sold Services	068																	
Other	069																	
TOTAL (Lines 051 thru 089)	090					4.44	8,667	18.20	35,488	0.01	24							22.65
GRAND TOTAL																		
(Lines 030 + 050 + 090)	099	6.99	13,623	4.61	9,003	5.49	10,717	18.20	35,488	4.90	9,561	2.51	4,895	22.66	44,177			65.36

EXHIBIT 61

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue		RHCF	Revenue - Other	Total
		0463	0160	0161
Analysis of Total Operating Revenue				
Medicaid Net Revenue				
A. Social Services	011	7,984,309		7,984,309
B. Managed Care Provider	025			
C. Other Services	012			
TOTAL MEDICAID NET REVENUE	001	7,984,309		7,984,309
Medicare Net Revenue				
A. Part A - All Income	002	861,110		861,110
B Part B - Income	003	68,065		68,065
C. Part B - Final Settlement	004			
D. Managed Care Provider	026			
TOTAL MEDICARE NET REVENUE	013	929,175		929,175
Private Patient Revenue	005	1,797,531		1,797,531
Other Net Patient Revenue	006			
TOTAL NET PATIENT REVENUE	010	10,711,015		10,711,015
All Other Operating Revenue*	015	114,718		114,718
TOTAL OPERATING REVENUE	020	10,825,733		10,825,733

*Line 0015 Column 00160 would be used for reporting revenue for all other operating revenue centers.

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue (continued)		Blue Cross	Travelers	Other
		0243	0244	0245
Part B Cash Receipts By Intermediary				
For Report Year	021			
For Prior Year	022			
All Other Years	023			
TOTAL	030			

Schedule 9 - Property Expenses (All Property Expenses Must be Reported on This Schedule)		Amount	Cost Center Line No. Affected
		0270	0271
Building/Fixed Equipment:			
Depreciation - Owned Assets	001		001
Depreciation - Captitalized Assets	002		001
Interest - Mortgage(s)	003		003
Interest - Capitalized Leases	004		003
Rent	005	1,813,432	001
Property Insurance	006	17,004	005
Boiler Insurance	007		
	008		
	009		
	010		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	011		
Interest - Mortgages	012		
Amortization	013		
TOTAL (Lines 001 thru 013)	015	1,830,436	
Land/Leasehold Improvements:			
Depreciation - Owned Assets	016		001
Depreciation - Capitalized Leases	017		001
Amortization	018	95,482	001
Interest - Owned Assets	019		003
Interest - Capitalized Leases	020		003
Rent	021		001
	022		
	025		
	026		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	027		
Interest - Mortgages	028		
Amortization	029		
TOTAL (Lines 016 thru 022 + 025 thru 029)	031	95,482	
Moveable Equipment:			
Depreciation - Owned Assets	032	80,252	002
Depreciation - Capitalized Leases	033	43,733	002
Interest - Mortgage(s)	034		003
Interest - Capitalized Leases	035	3,183	003
Interest - Other	036		
Equipment Rent A	037		
Equipment Rent B	038		
Equipment Rent C	039	23,720	043
Equipment Rent D	040		
Equipment Rent E	041	21,182	004
Equipment Rent F	042	350	006
Equipment Rent G	043		
Equipment Rent H	044		
Equipment Rent I	045	4,453	011
Equipment Rent J	046		
Equipment Rent K	047		
Equipment Rent L	048		
Equipment Rent M	049		
Equipment Rent N	050		
Equipment Rent O	051		
Equipment Rent P	052		
Equipment Rent Q	053		
Equipment Rent R	054		
Equipment Rent S	055		
Equipment Rent T	056		
Equipment Rent U	057		
Equipment Rent V	058		
Equipment Rent W	059		
Equipment Rent X	060		
Equipment Rent Y	061		
Equipment Rent Z	062		
Computer Equipment Rent	063	52,528	004
TOTAL Rental (Lines 37 thru 63)	096	102,233	
Auto Insurance	064	1,628	006
Rent: All Capitalized Leases (Sch. 9A)	065	79,954	
	067		
TOTAL (Lines 032 thru 067)	070	310,983	
Other:			
Sales Tax	071	15,857	005
Real Estate Taxes	023	157,363	006
Payments in lieu of Taxes	094		006
Occupancy Taxes	024		006
Mortgage Insurance Premium	072		
Fees & Charges: 28A Fees	073		005
Fees: Outside PRI Assessor	074		
Other Fees (Specify):			
	075		
Amortization - Mortgage Expense	076		
Amortization - Organization Expense	077	11,590	005
Amortization - Legal Expense	078		005
Nurse Aide Training Costs	079		
Nurse Aide Testing Costs	080	-1,400	005
NYS Revenue Assessment	081	544,120	005
Bad Debts	082		005
Telephone Equipment - Depreciation	091		
Telephone Equipment - Interest	092		
Telephone Equipment - Rental	093		
	083		
	084		
	085		

Exhibit H Statement of Functional Expenses		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Nonrevenue Support Services:												
Depreciation Leases & Rental	001							1,908,914				1,908,914
Depreciation, Major Movable Equip.	002							123,985				123,985
Interest on Capital Debt	003								3,183			3,183
Fiscal Services	004				80,500	12,350	87,879	73,710	4,930			259,369
Administrative Services	005	217,000		54,742	401,302		18,246	11,590	750,314			1,453,194
Plant Operation & Maint.	006	61,092		14,907		16,121	49,143	350	399,433			541,046
Grounds	007											
Security	008				13,112		72					13,184
Laundry and Linen	009	24,389		5,687		48,067	907					79,050
Housekeeping	010	317,644		75,448		36,307	6,439					435,838
Patient Food Service	011	387,950		92,505		274,190		4,453				759,098
Cafeteria	012											
Nursing Administration	013	221,112		50,716								271,828
Activities Program	014	74,487		17,823	990	1,837	11,557					106,694
Nonphysician Education	015											
Medical Education	016											
Medical Director's Office	017		24,009									24,009
Housing	018											
Medical Records	019	68,059		15,890		317						84,266
Utilization Review	020											
Social Service	021	118,273		27,592	1,200		13,771					160,836
Transportation	022											
TOTAL (Lines 001 thru 022)	030	1,490,006	24,009	355,310	497,104	389,189	188,014	2,123,002	1,157,860			6,224,494
Ancillary Services												
Laboratory Services	031				8,179	5,498						13,677
Electrocardiology	032											
Electroencephalogy	033											
Radiology	034					8,644						8,644
Inhalation Therapy	035											
Podiatry	036											
Dental	037				21,600							21,600
Psychiatric	038				6,250							6,250
Physical Therapy	039				13,750	750	243,227					257,727
Occupational Therapy	040					848	280,031					280,879
Speech/Hearing Therapy	041					635	95,720					96,355
Pharmacy	042					167,562						167,562
Central Service Supply	043					95,058	14,064	23,720				132,842
Medical Staff Services	044											

Exhibit H Statement of Functional Expenses (continued)		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Ancillary Other (specify below):												
	045											
	046											
	047											
TOTAL (Lines 031 thru 047)	050				49,779	278,995	633,042	23,720				985,536
Program Services												
Res. Health Care Fac.	051	1,744,323		417,336			1,462,507					3,624,166
Adult Care Facility	053											
I.C.F. Mental Retardation	054											
Independent Living	055											
Outpatient Clinics	057											
Home Health Care	059											
Homemaker-Services	060											
Meals on Wheels	061											
Research	062											
Physicians' Office & Other Rentals	063											
Gift Shop	064											
Public Restaurant	065											
Fund Raising	066											
Barber & Beauty Shops	067											
Sold Services	068											
Other	069											
TOTAL (Lines 051 thru 089)	090	1,744,323		417,336			1,462,507					3,624,166
GRAND TOTAL (Lines 030 + 050 + 090)	099	3,234,329	24,009	772,646	546,883	668,184	2,283,563	2,146,722	1,157,860			10,834,196

Schedule P Staff Turnover RHCF		Total number of employees									
		1-Jan	31-Mar	30-Jun	30-Sep	31-Dec	Full Time as of 12/31	Part Time as of 12/31	Employees retained as of 12/31, who were employed on 1/1	Employees Hired (Year)	Employees Terminated (Year)
		0770	0771	0772	0773	0774	0775	0776	0777	0778	0779
NON-CONTRACT STAFF											
RN Director of Services	001	2	2	2	2	2	1	1	2		
Nurses with Administrative Duties	002	3	4	4	4	4	2	2	2	3	2
Registered Nurses	003	1	1	2	1	2	2		1	2	1
Licensed Practical/License Vocational Nurses	004	19	14	13	11	9	7	2	7	3	13
Certified Nurse Aides	005	39	45	38	38	39	20	19	22	39	40
Total Lines 1 - 5 Employees	006	64	66	59	56	56	32	24	34	47	56
Occupational Therapists	007										
Occupational Therapy Assistants	008										
Occupational Therapy Aides	009										
Physical Therapists	010										
Physical Therapists Assistants	011										
Physical Therapy Aides	012										
Speech/Language Pathologist	013										
Respiratory Therapists	014										
Qualified Social Workers	015	2	3	3	2	2	2			4	4
Other Social Services	016										
Total Lines 7 - 16 Employees	017	2	3	3	2	2	2			4	4
Total Lines 6 and 17	018	66	69	62	58	58	34	24	34	51	60
CONTRACT STAFF											
RN Director of Services	019										
Nurses with Administrative Duties	020										
Registered Nurses	021										
Licensed Practical/License Vocational Nurses	022	4	3	1	11	2			2	12	
Certified Nurse Aides	023	1			9	3			1	12	1
Total Lines 19 - 23 Employees	024	5	3	1	20	5			3	24	1
Occupational Therapists	025		1	1	8						
Occupational Therapy Assistants	026		2		4						
Occupational Therapy Aides	027										
Physical Therapists	028		1	1	9						
Physical Therapists Assistants	029		2		10						1
Physical Therapy Aides	030		1								
Speech/Language Pathologist	031				2						
Respiratory Therapists	032										
Qualified Social Workers	033										
Other Social Services	034										
Total Lines 25 - 34 Employees	035		7	2	33						1
Total Lines 24 and 35	036	5	10	3	53	5			3	24	2

Schedule 4 - Salaries And Wages		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
NonRevenue Support Services:										
Fiscal Services	004									
Administration Services	005	113,758					103,242			217,000
Plant Operation & Maint.	006	56,538						4,554		61,092
Grounds	007									
Security	008									
Laundry and Linen	009							24,389		24,389
Housekeeping	010	51,628						266,016		317,644
Patient Food Service	011	84,139	89,318					214,493		387,950
Cafeteria	012									
Nursing Administration	013	165,208		55,904						221,112
Activities Program	014					74,487				74,487
NonPhysician Education	015									
Medical Education	016									
Medical Director's Office	017									
Housing	018									
Medical Records	019		68,059							68,059
Utilization Review	020									
Social Services	021					76,429	41,844			118,273
Transportation	022									
TOTAL	030	471,271	157,377	55,904		150,916	145,086	509,452		1,490,006
Ancillary Services:										
Laboratory Services	031									
Electrocardiology	032									
Electroencephalogy	033									
Radiology	034									
Inhalation Therapy	035									
Podiatry	036									
Dental	037									
Psychiatric	038									
Physical Therapy	039									
Occupational Therapy	040									
Speech/Hearing Therapy	041									
Pharmacy	042									
Central Service Supply	043									
Medical Staff Services	044									

Schedule 4 - Salaries And Wages (continued)		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
Ancillary Services - Other (specify below):										
	045									
	046									
	047									
TOTAL (Lines 031 thru 047)	050									
Program Services:										
Res. Health Care Fac.	051			148,575	594,835	1,000,913				1,744,323
Adult Care Facility	053									
I.C.F. Mental Retardation	054									
Independent Living	055									
Outpatient Clinics	057									
Home Health Care	059									
Homemaker-Services	060									
Meals on Wheels	061									
Research	062									
Physicians' Office & Other Rentals	063									
Gift Shop	064									
Public Restaurant	065									
Fund Raising	066									
Barber & Beauty Shops	067									
Sold Services	068									
Other	069									
TOTAL (Lines 051 thru 089)	090			148,575	594,835	1,000,913				1,744,323
GRAND TOTAL (Lines 030 + 050 + 090)	099	471,271	157,377	204,479	594,835	1,151,829	145,086	509,452		3,234,329

Schedule 5 - Full Time Equivalents & Hours Paid		Number of Wks for Calculation
		0140
IMPORTANT:		
This box must be completed. Enter on line 001 the number of weeks used		
in the calculation of the columns "Hours Paid" on Schedule 5 and "Hours Worked"		
on Schedule 5A. A typical entry would be 52 wks. If the data is not for		
52 wks, enter the number of weeks included in the calculation.	001	52

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
NonRevenue Support Services:																		
Fiscal Services	004																	
Administration Services	005	1.13	2,195									1.07	2,080					2.20
Plant Operation & Maint.	006	1.05	2,056											0.22	428			1.27
Grounds	007																	
Security	008																	
Laundry and Linen	009													0.99	1,935			0.99
Housekeeping	010	1.06	2,064											10.78	21,027			11.84
Patient Food Service	011	1.91	3,715	2.72	5,299									9.51	18,535			14.14
Cafeteria	012																	
Nursing Administration	013	1.75	3,416			0.89	1,745											2.64
Activities Program	014									3.29	6,411							3.29
NonPhysician Education	015																	
Medical Education	016																	
Medical Director's Office	017																	
Housing	018																	
Medical Records	019			1.77	3,452													1.77
Utilization Review	020																	
Social Services	021									1.70	3,320	1.07	2,080					2.77
Transportation	022																	
TOTAL	030	6.90	13,446	4.49	8,751	0.89	1,745			4.99	9,731	2.14	4,160	21.50	41,925			40.91
Laboratory Services	031																	
Electrocardiology	032																	
Electroencephalogy	033																	
Radiology	034																	
Inhalation Therapy	035																	
Podiatry	036																	
Dental	037																	
Psychiatric	038																	
Physical Therapy	039																	
Occupational Therapy	040																	
Speech/Hearing Therapy	041																	
Pharmacy	042																	
Central Service Supply	043																	
Medical Staff Services	044																	

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
Ancillary Services - Other																		
(specify below):																		
	045																	
	046																	
	047																	
TOTAL (Lines 031 thru 047)	050																	
Res. Health Care Fac.	051					2.54	4,945	14.49	28,264	37.65	73,411							54.68
Adult Care Facility	053																	
I.C.F. Mental Retardation	054																	
Independent Living	055																	
Outpatient Clinics	057																	
Home Health Care	059																	
Homemaker-Services	060																	
Meals on Wheels	061																	
Research	062																	
Physicians' Office & Other	063																	
Gift Shop	064																	
Public Restaurant	065																	
Fund Raising	066																	
Barber & Beauty Shops	067																	
Sold Services	068																	
Other	069																	
TOTAL (Lines 051 thru 089)	090					2.54	4,945	14.49	28,264	37.65	73,411							54.68
GRAND TOTAL																		
(Lines 030 + 050 + 090)	099	6.90	13,446	4.49	8,751	3.43	6,690	14.49	28,264	42.64	83,142	2.14	4,160	21.50	41,925			95.59

EXHIBIT 62

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue		RHCF	Revenue - Other	Total
		0463	0160	0161
Analysis of Total Operating Revenue				
Medicaid Net Revenue				
A. Social Services	011	7,968,563		7,968,563
B. Managed Care Provider	025			
C. Other Services	012			
TOTAL MEDICAID NET REVENUE	001	7,968,563		7,968,563
Medicare Net Revenue				
A. Part A - All Income	002	1,179,826		1,179,826
B Part B - Income	003	120,041		120,041
C. Part B - Final Settlement	004			
D. Managed Care Provider	026			
TOTAL MEDICARE NET REVENUE	013	1,299,867		1,299,867
Private Patient Revenue	005	1,926,394		1,926,394
Other Net Patient Revenue	006			
TOTAL NET PATIENT REVENUE	010	11,194,824		11,194,824
All Other Operating Revenue*	015	-72,489		-72,489
TOTAL OPERATING REVENUE	020	11,122,335		11,122,335

*Line 0015 Column 00160 would be used for reporting revenue for all other operating revenue centers.

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue (continued)		Blue Cross	Travelers	Other
		0243	0244	0245
Part B Cash Receipts By Intermediary				
For Report Year	021			
For Prior Year	022			
All Other Years	023			
TOTAL	030			

Schedule 9 - Property Expenses (All Property Expenses Must be Reported on This Schedule)		Amount	Cost Center Line No. Affected
		0270	0271
Building/Fixed Equipment:			
Depreciation - Owned Assets	001		001
Depreciation - Captitalized Assets	002		001
Interest - Mortgage(s)	003		003
Interest - Capitalized Leases	004		003
Rent	005	1,937,157	001
Property Insurance	006	16,727	005
Boiler Insurance	007		
	008		
	009		
	010		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	011		
Interest - Mortgages	012		
Amortization	013		
TOTAL (Lines 001 thru 013)	015	1,953,884	
Land/Leasehold Improvements:			
Depreciation - Owned Assets	016		001
Depreciation - Capitalized Leases	017		001
Amortization	018	107,691	001
Interest - Owned Assets	019		003
Interest - Capitalized Leases	020		003
Rent	021		001
	022		
	025		
	026		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	027		
Interest - Mortgages	028		
Amortization	029		
TOTAL (Lines 016 thru 022 + 025 thru 029)	031	107,691	
Moveable Equipment:			
Depreciation - Owned Assets	032	91,602	002
Depreciation - Capitalized Leases	033	43,733	002
Interest - Mortgage(s)	034		003
Interest - Capitalized Leases	035	197	003
Interest - Other	036		
Equipment Rent A	037	553	006
Equipment Rent B	038		
Equipment Rent C	039	16,471	043
Equipment Rent D	040		
Equipment Rent E	041	19,072	004
Equipment Rent F	042		
Equipment Rent G	043		
Equipment Rent H	044		
Equipment Rent I	045	3,679	011
Equipment Rent J	046		
Equipment Rent K	047		
Equipment Rent L	048		
Equipment Rent M	049		
Equipment Rent N	050		
Equipment Rent O	051		
Equipment Rent P	052		
Equipment Rent Q	053		
Equipment Rent R	054		
Equipment Rent S	055		
Equipment Rent T	056		
Equipment Rent U	057		
Equipment Rent V	058		
Equipment Rent W	059		
Equipment Rent X	060		
Equipment Rent Y	061		
Equipment Rent Z	062		
Computer Equipment Rent	063	54,413	004
TOTAL Rental (Lines 37 thru 63)	096	94,188	
Auto Insurance	064	3,428	006
Rent: All Capitalized Leases (Sch. 9A)	065	9,832	
	067		
TOTAL (Lines 032 thru 067)	070	242,980	
Other:			
Sales Tax	071	31,142	005
Real Estate Taxes	023	157,779	006
Payments in lieu of Taxes	094		006
Occupancy Taxes	024		006
Mortgage Insurance Premium	072		
Fees & Charges: 28A Fees	073		005
Fees: Outside PRI Assessor	074		
Other Fees (Specify):			
	075		
Amortization - Mortgage Expense	076		
Amortization - Organization Expense	077	12,590	005
Amortization - Legal Expense	078		005
Nurse Aide Training Costs	079		
Nurse Aide Testing Costs	080	1,300	005
NYS Revenue Assessment	081	601,465	005
Bad Debts	082		005
Telephone Equipment - Depreciation	091		
Telephone Equipment - Interest	092		
Telephone Equipment - Rental	093		
	083		
	084		
	085		

Exhibit H Statement of Functional Expenses		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Nonrevenue Support Services:												
Depreciation Leases & Rental	001							2,044,848				2,044,848
Depreciation, Major Movable Equip.	002							135,335				135,335
Interest on Capital Debt	003								197			197
Fiscal Services	004				79,050	9,598	34,087	73,485	6,457			202,677
Administrative Services	005	222,060		43,658	445,214		19,843	12,590	884,128			1,627,493
Plant Operation & Maint.	006	60,344		11,650		12,027	83,032	553	375,590			543,196
Grounds	007											
Security	008				11,419							11,419
Laundry and Linen	009	24,317		4,426		41,026	254					70,023
Housekeeping	010	328,932		63,739		55,381	1,675					449,727
Patient Food Service	011	390,634		74,890		277,807	419	3,679				747,429
Cafeteria	012											
Nursing Administration	013	169,137		34,015								203,152
Activities Program	014	83,892		16,298	1,555	18	10,605					112,368
Nonphysician Education	015											
Medical Education	016											
Medical Director's Office	017		24,009									24,009
Housing	018											
Medical Records	019	60,221		11,564		151						71,936
Utilization Review	020											
Social Service	021	137,983		27,276	800		29,481					195,540
Transportation	022											
TOTAL (Lines 001 thru 022)	030	1,477,520	24,009	287,516	538,038	396,008	179,396	2,270,490	1,266,372			6,439,349
Ancillary Services												
Laboratory Services	031				8,028							8,028
Electrocardiology	032											
Electroencephalogy	033											
Radiology	034					15,626						15,626
Inhalation Therapy	035											
Podiatry	036											
Dental	037				21,600							21,600
Psychiatric	038											
Physical Therapy	039	259,635		47,972	17,084	2,811	39,200					366,702
Occupational Therapy	040	171,710		32,158			51,322					255,190
Speech/Hearing Therapy	041	21,262		3,790		5,731						30,783
Pharmacy	042					159,575						159,575
Central Service Supply	043					74,585	32,481	16,471				123,537
Medical Staff Services	044											

Exhibit H Statement of Functional Expenses (continued)		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Ancillary Other (specify below):												
	045											
	046											
	047											
TOTAL (Lines 031 thru 047)	050	452,607		83,920	46,712	258,328	123,003	16,471				981,041
Program Services												
Res. Health Care Fac.	051	1,615,019		314,173			1,772,673					3,701,865
Adult Care Facility	053											
I.C.F. Mental Retardation	054											
Independent Living	055											
Outpatient Clinics	057											
Home Health Care	059											
Homemaker-Services	060											
Meals on Wheels	061											
Research	062											
Physicians' Office & Other Rentals	063											
Gift Shop	064											
Public Restaurant	065											
Fund Raising	066											
Barber & Beauty Shops	067											
Sold Services	068											
Other	069											
TOTAL (Lines 051 thru 089)	090	1,615,019		314,173			1,772,673					3,701,865
GRAND TOTAL (Lines 030 + 050 + 090)	099	3,545,146	24,009	685,609	584,750	654,336	2,075,072	2,286,961	1,266,372			11,122,255

Schedule P Staff Turnover RHCF		Total number of employees									
		1-Jan	31-Mar	30-Jun	30-Sep	31-Dec	Full Time as of 12/31	Part Time as of 12/31	Employees retained as of 12/31, who were employed on 1/1	Employees Hired (Year)	Employees Terminated (Year)
		0770	0771	0772	0773	0774	0775	0776	0777	0778	0779
NON-CONTRACT STAFF											
RN Director of Services	001	1	1	1	1	1	1		1		
Nurses with Administrative Duties	002	5	4	5	3	3	2	1	1	5	7
Registered Nurses	003	3	2	2	1	1	1		1	2	4
Licensed Practical/License Vocational Nurses	004	20	19	18	18	23	15	8	10	9	6
Certified Nurse Aides	005	54	54	49	58	45	23	22	30	41	50
Total Lines 1 - 5 Employees	006	83	80	75	81	73	42	31	43	57	67
Occupational Therapists	007		1	3	3	3		3		3	
Occupational Therapy Assistants	008		2	5	5	5	3	2		5	
Occupational Therapy Aides	009										
Physical Therapists	010			2	4	4		4		4	
Physical Therapists Assistants	011		3	5	5	6	2	4		6	
Physical Therapy Aides	012										
Speech/Language Pathologist	013			2	2	2		2		2	
Respiratory Therapists	014										
Qualified Social Workers	015	2	2	2	2	2	2			3	3
Other Social Services	016										
Total Lines 7 - 16 Employees	017	2	8	19	21	22	7	15		23	3
Total Lines 6 and 17	018	85	88	94	102	95	49	46	43	80	70
CONTRACT STAFF											
RN Director of Services	019										
Nurses with Administrative Duties	020										
Registered Nurses	021		1								
Licensed Practical/License Vocational Nurses	022	8	5	8	5	8					
Certified Nurse Aides	023	6	3	4	6	4					
Total Lines 19 - 23 Employees	024	14	9	12	11	12					
Occupational Therapists	025										
Occupational Therapy Assistants	026										
Occupational Therapy Aides	027										
Physical Therapists	028										
Physical Therapists Assistants	029										
Physical Therapy Aides	030										
Speech/Language Pathologist	031										
Respiratory Therapists	032										
Qualified Social Workers	033										
Other Social Services	034										
Total Lines 25 - 34 Employees	035										
Total Lines 24 and 35	036	14	9	12	11	12					

Schedule 4 - Salaries And Wages		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
NonRevenue Support Services:										
Fiscal Services	004									
Administration Services	005	117,694					104,366			222,060
Plant Operation & Maint.	006	60,344								60,344
Grounds	007									
Security	008									
Laundry and Linen	009							24,317		24,317
Housekeeping	010	51,535						277,397		328,932
Patient Food Service	011	79,469	82,300					228,865		390,634
Cafeteria	012									
Nursing Administration	013	137,376		31,761						169,137
Activities Program	014					83,892				83,892
NonPhysician Education	015									
Medical Education	016									
Medical Director's Office	017									
Housing	018									
Medical Records	019		60,221							60,221
Utilization Review	020									
Social Services	021					89,531	48,452			137,983
Transportation	022									
TOTAL	030	446,418	142,521	31,761		173,423	152,818	530,579		1,477,520
Ancillary Services:										
Laboratory Services	031									
Electrocardiology	032									
Electroencephalogy	033									
Radiology	034									
Inhalation Therapy	035									
Podiatry	036									
Dental	037									
Psychiatric	038									
Physical Therapy	039		140,150			119,485				259,635
Occupational Therapy	040		77,236			94,474				171,710
Speech/Hearing Therapy	041		21,262							21,262
Pharmacy	042									
Central Service Supply	043									
Medical Staff Services	044									

Schedule 4 - Salaries And Wages (continued)		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
Ancillary Services - Other (specify below):										
	045									
	046									
	047									
TOTAL (Lines 031 thru 047)	050		238,648			213,959				452,607
Program Services:										
Res. Health Care Fac.	051			97,767	486,839	1,030,413				1,615,019
Adult Care Facility	053									
I.C.F. Mental Retardation	054									
Independent Living	055									
Outpatient Clinics	057									
Home Health Care	059									
Homemaker-Services	060									
Meals on Wheels	061									
Research	062									
Physicians' Office & Other Rentals	063									
Gift Shop	064									
Public Restaurant	065									
Fund Raising	066									
Barber & Beauty Shops	067									
Sold Services	068									
Other	069									
TOTAL (Lines 051 thru 089)	090			97,767	486,839	1,030,413				1,615,019
GRAND TOTAL (Lines 030 + 050 + 090)	099	446,418	381,169	129,528	486,839	1,417,795	152,818	530,579		3,545,146

Schedule 5 - Full Time Equivalents & Hours Paid		Number of Wks for Calculation
		0140
IMPORTANT:		
This box must be completed. Enter on line 001 the number of weeks used		
in the calculation of the columns "Hours Paid" on Schedule 5 and "Hours Worked"		
on Schedule 5A. A typical entry would be 52 wks. If the data is not for		
52 wks, enter the number of weeks included in the calculation.	001	52

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
NonRevenue Support Services:																		
Fiscal Services	004																	
Administration Services	005	1.00	2,080									1.06	2,072					2.06
Plant Operation & Maint.	006	1.07	2,080															1.07
Grounds	007																	
Security	008																	
Laundry and Linen	009													0.99	1,926			0.99
Housekeeping	010	1.07	2,080											11.02	21,485			12.09
Patient Food Service	011	1.89	3,682	2.25	4,380									9.75	19,007			13.89
Cafeteria	012																	
Nursing Administration	013	1.65	3,218			0.47	917											2.12
Activities Program	014									3.60	7,024							3.60
NonPhysician Education	015																	
Medical Education	016																	
Medical Director's Office	017																	
Housing	018																	
Medical Records	019			1.60	3,129													1.60
Utilization Review	020																	
Social Services	021									1.98	3,861	1.10	2,136					3.08
Transportation	022																	
TOTAL	030	6.68	13,140	3.85	7,509	0.47	917			5.58	10,885	2.16	4,208	21.76	42,418			40.50
Laboratory Services	031																	
Electrocardiology	032																	
Electroencephalogy	033																	
Radiology	034																	
Inhalation Therapy	035																	
Podiatry	036																	
Dental	037																	
Psychiatric	038																	
Physical Therapy	039			1.22	2,384					2.26	4,410							3.48
Occupational Therapy	040			0.85	1,657					1.80	3,519							2.65
Speech/Hearing Therapy	041			0.20	390													0.20
Pharmacy	042																	
Central Service Supply	043																	
Medical Staff Services	044																	

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
Ancillary Services - Other																		
(specify below):																		
	045																	
	046																	
	047																	
TOTAL (Lines 031 thru 047)	050			2.27	4,431					4.06	7,929							6.33
Res. Health Care Fac.	051					1.53	2,981	9.97	19,440	36.43	71,031							47.93
Adult Care Facility	053																	
I.C.F. Mental Retardation	054																	
Independent Living	055																	
Outpatient Clinics	057																	
Home Health Care	059																	
Homemaker-Services	060																	
Meals on Wheels	061																	
Research	062																	
Physicians' Office & Other	063																	
Gift Shop	064																	
Public Restaurant	065																	
Fund Raising	066																	
Barber & Beauty Shops	067																	
Sold Services	068																	
Other	069																	
TOTAL (Lines 051 thru 089)	090					1.53	2,981	9.97	19,440	36.43	71,031							47.93
GRAND TOTAL (Lines 030 + 050 + 090)	099	6.68	13,140	6.12	11,940	2.00	3,898	9.97	19,440	46.07	89,845	2.16	4,208	21.76	42,418			94.76

EXHIBIT 63

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue		RHCF	Revenue - Other	Total
		0463	0160	0161
Analysis of Total Operating Revenue				
Medicaid Net Revenue				
A. Social Services	011	8,274,662		8,274,662
B. Managed Care Provider	025			
C. Other Services	012			
TOTAL MEDICAID NET REVENUE	001	8,274,662		8,274,662
Medicare Net Revenue				
A. Part A - All Income	002	1,201,626		1,201,626
B Part B - Income	003	98,447		98,447
C. Part B - Final Settlement	004			
D. Managed Care Provider	026			
TOTAL MEDICARE NET REVENUE	013	1,300,073		1,300,073
Private Patient Revenue	005	1,910,204		1,910,204
Other Net Patient Revenue	006	648,071		648,071
TOTAL NET PATIENT REVENUE	010	12,133,010		12,133,010
All Other Operating Revenue*	015	116,581		116,581
TOTAL OPERATING REVENUE	020	12,249,591		12,249,591

*Line 0015 Column 00160 would be used for reporting revenue for all other operating revenue centers.

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue (continued)		Blue Cross	Travelers	Other
		0243	0244	0245
Part B Cash Receipts By Intermediary				
For Report Year	021			
For Prior Year	022			
All Other Years	023			
TOTAL	030			

Schedule 9 - Property Expenses (All Property Expenses Must be Reported on This Schedule)		Amount	Cost Center Line No. Affected
		0270	0271
Building/Fixed Equipment:			
Depreciation - Owned Assets	001		001
Depreciation - Captitalized Assets	002		001
Interest - Mortgage(s)	003		003
Interest - Capitalized Leases	004		003
Rent	005	2,680,000	001
Property Insurance	006	19,484	005
Boiler Insurance	007		
	008		
	009		
	010		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	011		
Interest - Mortgages	012		
Amortization	013		
TOTAL (Lines 001 thru 013)	015	2,699,484	
Land/Leasehold Improvements:			
Depreciation - Owned Assets	016		001
Depreciation - Capitalized Leases	017		001
Amortization	018	125,097	001
Interest - Owned Assets	019		003
Interest - Capitalized Leases	020		003
Rent	021		001
	022		
	025		
	026		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	027		
Interest - Mortgages	028		
Amortization	029		
TOTAL (Lines 016 thru 022 + 025 thru 029)	031	125,097	
Moveable Equipment:			
Depreciation - Owned Assets	032	150,530	002
Depreciation - Capitalized Leases	033		002
Interest - Mortgage(s)	034		003
Interest - Capitalized Leases	035		003
Interest - Other	036		
Equipment Rent A	037	9,675	004
Equipment Rent B	038	1,300	004
Equipment Rent C	039	25,908	004
Equipment Rent D	040	4,129	004
Equipment Rent E	041	16,546	004
Equipment Rent F	042	3,679	004
Equipment Rent G	043	4,927	004
Equipment Rent H	044	6,149	004
Equipment Rent I	045	4,026	004
Equipment Rent J	046	7,617	051
Equipment Rent K	047	7,895	051
Equipment Rent L	048	959	051
Equipment Rent M	049	12,372	051
Equipment Rent N	050		
Equipment Rent O	051		
Equipment Rent P	052		
Equipment Rent Q	053		
Equipment Rent R	054		
Equipment Rent S	055		
Equipment Rent T	056		
Equipment Rent U	057		
Equipment Rent V	058		
Equipment Rent W	059		
Equipment Rent X	060		
Equipment Rent Y	061		
Equipment Rent Z	062		
Computer Equipment Rent	063		
TOTAL Rental (Lines 37 thru 63)	096	105,182	
Auto Insurance	064	3,750	006
Rent: All Capitalized Leases (Sch. 9A)	065		
	067		
TOTAL (Lines 032 thru 067)	070	259,462	
Other:			
Sales Tax	071	32,096	005
Real Estate Taxes	023	149,957	005
Payments in lieu of Taxes	094		005
Occupancy Taxes	024		005
Mortgage Insurance Premium	072		
Fees & Charges: 28A Fees	073		005
Fees: Outside PRI Assessor	074		
Other Fees (Specify):			
	075		
Amortization - Mortgage Expense	076		
Amortization - Organization Expense	077	12,590	005
Amortization - Legal Expense	078		005
Nurse Aide Training Costs	079		
Nurse Aide Testing Costs	080	1,990	005
NYS Revenue Assessment	081	567,852	005
Bad Debts	082	231,288	005
Telephone Equipment - Depreciation	091		
Telephone Equipment - Interest	092		
Telephone Equipment - Rental	093		
	083		
	084		
	085		
	086		
	087		
	088		
	089		
TOTAL (Lines 023, 024, 071 thru 094)	095	995,773	

Exhibit H Statement of Functional Expenses		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Nonrevenue Support Services:												
Depreciation Leases & Rental	001							2,805,097				2,805,097
Depreciation, Major Movable Equip.	002							150,530				150,530
Interest on Capital Debt	003											
Fiscal Services	004					10,188	24,329	76,339				110,856
Administrative Services	005	353,733		55,668	315,827	97			1,202,517			1,927,842
Plant Operation & Maint.	006	47,621		7,494		24,832	68,871		352,865			501,683
Grounds	007											
Security	008						11,726					11,726
Laundry and Linen	009	25,407		3,998		25,585						54,990
Housekeeping	010	344,338		54,189		58,799						457,326
Patient Food Service	011	404,285		63,623		278,421	280					746,609
Cafeteria	012											
Nursing Administration	013	266,867		42,533								309,400
Activities Program	014	87,123		13,711	90	1,291	20,311					122,526
Nonphysician Education	015											
Medical Education	016											
Medical Director's Office	017				24,009							24,009
Housing	018											
Medical Records	019	51,261		8,067		164						59,492
Utilization Review	020											
Social Service	021	92,878		14,616			3,255					110,749
Transportation	022											
TOTAL (Lines 001 thru 022)	030	1,673,513		263,899	339,926	399,377	128,772	3,031,966	1,555,382			7,392,835
Ancillary Services												
Laboratory Services	031				11,479							11,479
Electrocardiology	032											
Electroencephalogy	033											
Radiology	034						14,325					14,325
Inhalation Therapy	035											
Podiatry	036											
Dental	037				21,600							21,600
Psychiatric	038											
Physical Therapy	039	291,640		45,896	15,000	6,300	-1,503					357,333
Occupational Therapy	040	245,082		38,569								283,651
Speech/Hearing Therapy	041	37,318		5,873								43,191
Pharmacy	042					214,556						214,556
Central Service Supply	043											
Medical Staff Services	044											

Exhibit H Statement of Functional Expenses (continued)		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Ancillary Other (specify below):												
	045											
	046											
	047											
TOTAL (Lines 031 thru 047)	050	574,040		90,338	48,079	220,856	12,822					946,135
Program Services												
Res. Health Care Fac.	051	1,663,660		261,281	1,646,366	106,225		28,843	1,990			3,708,365
Adult Care Facility	053											
I.C.F. Mental Retardation	054											
Independent Living	055											
Outpatient Clinics	057											
Home Health Care	059											
Homemaker-Services	060											
Meals on Wheels	061											
Research	062											
Physicians' Office & Other Rentals	063											
Gift Shop	064											
Public Restaurant	065											
Fund Raising	066											
Barber & Beauty Shops	067											
Sold Services	068											
Other	069											
TOTAL (Lines 051 thru 089)	090	1,663,660		261,281	1,646,366	106,225		28,843	1,990			3,708,365
GRAND TOTAL (Lines 030 + 050 + 090)	099	3,911,213		615,518	2,034,371	726,458	141,594	3,060,809	1,557,372			12,047,335

Schedule P Staff Turnover RHCF		Total number of employees									
		1-Jan	31-Mar	30-Jun	30-Sep	31-Dec	Full Time as of 12/31	Part Time as of 12/31	Employees retained as of 12/31, who were employed on 1/1	Employees Hired (Year)	Employees Terminated (Year)
		0770	0771	0772	0773	0774	0775	0776	0777	0778	0779
NON-CONTRACT STAFF											
RN Director of Services	001	1	1	1	1	1	1		1		
Nurses with Administrative Duties	002	3	6	4	6	5	5		2	8	6
Registered Nurses	003										
Licensed Practical/License Vocational Nurses	004	14	13	11	9	12	8	4	7	18	21
Certified Nurse Aides	005	38	38	34	38	38	21	17	14	71	75
Total Lines 1 - 5 Employees	006	56	58	50	54	56	35	21	24	97	102
Occupational Therapists	007	3	3	3	3	8		8	3	5	
Occupational Therapy Assistants	008	5	4	4	4	4	3	1	4		1
Occupational Therapy Aides	009										
Physical Therapists	010	4	3	3	3	3		3	3		1
Physical Therapists Assistants	011	6	5	5	5	5	2	3	5		1
Physical Therapy Aides	012										
Speech/Language Pathologist	013	2	2	2	2	3		3	2	1	
Respiratory Therapists	014										
Qualified Social Workers	015	2	2	2	2	2	2		1	3	3
Other Social Services	016										
Total Lines 7 - 16 Employees	017	22	19	19	19	25	7	18	18	9	6
Total Lines 6 and 17	018	78	77	69	73	81	42	39	42	106	108
CONTRACT STAFF											
RN Director of Services	019										
Nurses with Administrative Duties	020										
Registered Nurses	021										
Licensed Practical/License Vocational Nurses	022										
Certified Nurse Aides	023										
Total Lines 19 - 23 Employees	024										
Occupational Therapists	025										
Occupational Therapy Assistants	026										
Occupational Therapy Aides	027										
Physical Therapists	028										
Physical Therapists Assistants	029										
Physical Therapy Aides	030										
Speech/Language Pathologist	031										
Respiratory Therapists	032										
Qualified Social Workers	033										
Other Social Services	034										
Total Lines 25 - 34 Employees	035										
Total Lines 24 and 35	036										

Schedule 4 - Salaries And Wages		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
NonRevenue Support Services:										
Fiscal Services	004									
Administration Services	005	123,344	125,814				104,575			353,733
Plant Operation & Maint.	006	46,784						837		47,621
Grounds	007									
Security	008									
Laundry and Linen	009							25,407		25,407
Housekeeping	010							344,338		344,338
Patient Food Service	011	80,087	34,029					290,169		404,285
Cafeteria	012									
Nursing Administration	013	162,534	104,333							266,867
Activities Program	014							87,123		87,123
NonPhysician Education	015									
Medical Education	016									
Medical Director's Office	017									
Housing	018									
Medical Records	019						51,261			51,261
Utilization Review	020									
Social Services	021	92,878								92,878
Transportation	022									
TOTAL	030	505,627	264,176				155,836	747,874		1,673,513
Ancillary Services:										
Laboratory Services	031									
Electrocardiology	032									
Electroencephalogy	033									
Radiology	034									
Inhalation Therapy	035									
Podiatry	036									
Dental	037									
Psychiatric	038									
Physical Therapy	039	69,331	38,068			184,241				291,640
Occupational Therapy	040		78,035			167,047				245,082
Speech/Hearing Therapy	041		37,318							37,318
Pharmacy	042									
Central Service Supply	043									
Medical Staff Services	044									

Schedule 4 - Salaries And Wages (continued)		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
Ancillary Services - Other (specify below):										
	045									
	046									
	047									
TOTAL (Lines 031 thru 047)	050	69,331	153,421			351,288				574,040
Program Services:										
Res. Health Care Fac.	051			57,152	545,725	1,060,783				1,663,660
Adult Care Facility	053									
I.C.F. Mental Retardation	054									
Independent Living	055									
Outpatient Clinics	057									
Home Health Care	059									
Homemaker-Services	060									
Meals on Wheels	061									
Research	062									
Physicians' Office & Other Rentals	063									
Gift Shop	064									
Public Restaurant	065									
Fund Raising	066									
Barber & Beauty Shops	067									
Sold Services	068									
Other	069									
TOTAL (Lines 051 thru 089)	090			57,152	545,725	1,060,783				1,663,660
GRAND TOTAL (Lines 030 + 050 + 090)	099	574,958	417,597	57,152	545,725	1,412,071	155,836	747,874		3,911,213

Schedule 5 - Full Time Equivalents & Hours Paid		Number of Wks for Calculation
		0140
IMPORTANT:		
This box must be completed. Enter on line 001 the number of weeks used		
in the calculation of the columns "Hours Paid" on Schedule 5 and "Hours Worked"		
on Schedule 5A. A typical entry would be 52 wks. If the data is not for		
52 wks, enter the number of weeks included in the calculation.	001	52

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
NonRevenue Support Services:																		
Fiscal Services	004																	
Administration Services	005	1.61	3,145	1.07	2,088							1.71	3,332					4.39
Plant Operation & Maint.	006	0.94	1,840											0.04	80			0.98
Grounds	007																	
Security	008																	
Laundry and Linen	009													0.99	1,921			0.99
Housekeeping	010													12.71	24,785			12.71
Patient Food Service	011	3.44	6,714	0.48	936									11.63	22,671			15.55
Cafeteria	012																	
Nursing Administration	013	1.07	2,088	1.71	3,332													2.78
Activities Program	014													3.50	6,819			3.50
NonPhysician Education	015																	
Medical Education	016																	
Medical Director's Office	017																	
Housing	018																	
Medical Records	019											1.07	2,088					1.07
Utilization Review	020																	
Social Services	021	2.00	3,904															2.00
Transportation	022																	
TOTAL	030	9.06	17,691	3.26	6,356							2.78	5,420	28.87	56,276			43.97
Laboratory Services	031																	
Electrocardiology	032																	
Electroencephalogy	033																	
Radiology	034																	
Inhalation Therapy	035																	
Podiatry	036																	
Dental	037																	
Psychiatric	038																	
Physical Therapy	039	0.41	792	0.53	1,028					4.27	8,321							5.21
Occupational Therapy	040			0.89	1,726					3.29	6,410							4.18
Speech/Hearing Therapy	041			0.39	756													0.39
Pharmacy	042																	
Central Service Supply	043																	
Medical Staff Services	044																	

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
Ancillary Services - Other																		
(specify below):																		
	045																	
	046																	
	047																	
TOTAL (Lines 031 thru 047)	050	0.41	792	1.81	3,510					7.56	14,731							9.78
Res. Health Care Fac.	051	1.99	3,885			2.50	4,879	11.88	23,172	37.10	72,351							53.47
Adult Care Facility	053																	
I.C.F. Mental Retardation	054																	
Independent Living	055																	
Outpatient Clinics	057																	
Home Health Care	059																	
Homemaker-Services	060																	
Meals on Wheels	061																	
Research	062																	
Physicians' Office & Other Rentals	063																	
Gift Shop	064																	
Public Restaurant	065																	
Fund Raising	066																	
Barber & Beauty Shops	067																	
Sold Services	068																	
Other	069																	
TOTAL (Lines 051 thru 089)	090	1.99	3,885			2.50	4,879	11.88	23,172	37.10	72,351							53.47
GRAND TOTAL																		
(Lines 030 + 050 + 090)	099	11.46	22,368	5.07	9,866	2.50	4,879	11.88	23,172	44.66	87,082	2.78	5,420	28.87	56,276			107.22

EXHIBIT 64

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue		RHCF	Revenue - Other	Total
		0463	0160	0161
Analysis of Total Operating Revenue				
Medicaid Net Revenue				
A. Social Services	011	3,260,236		3,260,236
B. Managed Care Provider	025	1,673,849		1,673,849
C. Other Services	012			
TOTAL MEDICAID NET REVENUE	001	4,934,085		4,934,085
Medicare Net Revenue				
A. Part A - All Income	002	3,054,451		3,054,451
B Part B - Income	003	428,701		428,701
C. Part B - Final Settlement	004			
D. Managed Care Provider	026			
TOTAL MEDICARE NET REVENUE	013	3,483,152		3,483,152
Private Patient Revenue	005	910,351		910,351
Other Net Patient Revenue	006	1,048,056		1,048,056
TOTAL NET PATIENT REVENUE	010	10,375,644		10,375,644
All Other Operating Revenue*	015	803,500		803,500
TOTAL OPERATING REVENUE	020	11,179,144		11,179,144

*Line 0015 Column 00160 would be used for reporting revenue for all other operating revenue centers.

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue (continued)		Blue Cross	Travelers	Other
		0243	0244	0245
Part B Cash Receipts By Intermediary				
For Report Year	021			
For Prior Year	022			
All Other Years	023			
TOTAL	030			

Schedule 9 - Property Expenses (All Property Expenses Must be Reported on This Schedule)		Amount	Cost Center Line No. Affected
		0270	0271
Building/Fixed Equipment:			
Depreciation - Owned Assets	001		001
Depreciation - Captitalized Assets	002		001
Interest - Mortgage(s)	003		003
Interest - Capitalized Leases	004		003
Rent	005	2,655,527	001
Property Insurance	006	21,883	005
Boiler Insurance	007		
	008		
	009		
	010		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	011		
Interest - Mortgages	012		
Amortization	013		
TOTAL (Lines 001 thru 013)	015	2,677,410	
Land/Leasehold Improvements:			
Depreciation - Owned Assets	016		001
Depreciation - Capitalized Leases	017		001
Amortization	018	130,387	001
Interest - Owned Assets	019		003
Interest - Capitalized Leases	020		003
Rent	021		001
	022		
	025		
	026		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	027		
Interest - Mortgages	028		
Amortization	029		
TOTAL (Lines 016 thru 022 + 025 thru 029)	031	130,387	
Moveable Equipment:			
Depreciation - Owned Assets	032	107,230	002
Depreciation - Capitalized Leases	033		002
Interest - Mortgage(s)	034		003
Interest - Capitalized Leases	035		003
Interest - Other	036		
Equipment Rent A	037	75,957	005
Equipment Rent B	038	9,904	011
Equipment Rent C	039	2,690	051
Equipment Rent D	040		
Equipment Rent E	041		
Equipment Rent F	042		
Equipment Rent G	043		
Equipment Rent H	044		
Equipment Rent I	045		
Equipment Rent J	046		
Equipment Rent K	047		
Equipment Rent L	048		
Equipment Rent M	049		
Equipment Rent N	050		
Equipment Rent O	051		
Equipment Rent P	052		
Equipment Rent Q	053		
Equipment Rent R	054		
Equipment Rent S	055		
Equipment Rent T	056		
Equipment Rent U	057		
Equipment Rent V	058		
Equipment Rent W	059		
Equipment Rent X	060		
Equipment Rent Y	061		
Equipment Rent Z	062		
Computer Equipment Rent	063		
TOTAL Rental (Lines 37 thru 63)	096	88,551	
Auto Insurance	064		
Rent: All Capitalized Leases (Sch. 9A)	065		
	067		
TOTAL (Lines 032 thru 067)	070	195,781	
Other:			
Sales Tax	071	34,194	005
Real Estate Taxes	023	145,164	006
Payments in lieu of Taxes	094		006
Occupancy Taxes	024		006
Mortgage Insurance Premium	072		
Fees & Charges: 28A Fees	073		005
Fees: Outside PRI Assessor	074		
Other Fees (Specify):			
	075		
Amortization - Mortgage Expense	076		
Amortization - Organization Expense	077	9,574	005
Amortization - Legal Expense	078		005
Nurse Aide Training Costs	079		
Nurse Aide Testing Costs	080		
NYS Revenue Assessment	081	414,430	005
Bad Debts	082	203,049	005
Telephone Equipment - Depreciation	091		
Telephone Equipment - Interest	092		
Telephone Equipment - Rental	093		
	083		
	084		
	085		

Part III (1) - Related Company Financial Data - Payments to Related Companies		
		9343
Name of Company / Address:		
	001	TELEGRAPH REALTY
	002	600 BROADWAY
	003	LYNBROOK, NY 11563

Part III (1) - Related Company Financial Data - Payments to Related Companies (continued)1 Detail the actual cost of the related company in providing goods and services: (According to the Health Department Principles)		Col./Line	
		0240	0343
Reporting Period From (YY/MM/DD)	001		20/01/01
Reporting Period To (YY/MM/DD)	002		20/12/31
B. Functional Goods or Services Supplied (as defined			
in the NYS RHCF Reporting and Accounting Manual).			
If more than one function is supplied, complete			
Exhibit H (Rel. Co.). Indicate Rel. Co. function(s)			
by putting one (1) in column 00343, Lines 0003 thru 0007.			
Realty Company	003		1
Non-Realty Company	004		
Combination of Realty and Non-Realty Company	005		
	006		
	007		
TOTAL	008		1
C. Specify (below) Related Company Expenses Reported in			
Part IV, Exhibit H.			
Rent	010	0040/001	2,655,527
	011		
	012		
	013		
	014		
TOTAL (Lines 0010 thru 0014)	015		2,655,527
D. Total Expenses of Related Company (specify below):			
Depreciation	020		162,692
Administration	021		3,801
Mortgage Interest	022		613,998
Loss on Early Extinguishment of Debt	023		307,363
	024		
	025		
	026		
	027		
	028		
	029		
TOTAL (Lines 0020 thru 0029)	035		1,087,854

Part III (1) - Related Company Financial Data - Payments to Related Companies (continued)2 Detail the actual cost of the related company in providing goods and services: (According to the Health Department Principles)		Lender	Rate	Amount
		9241	0240	0343
E. Related Company Interest Expense:				
1. Other Than Real Prop. & Equip.				
	041			
	042			
	043			
	044			
2. Bldg. and Non-Move. Equip.				
A. 1st Mortgage	051		4.95	613,998
B. 2nd Mortgage	052			
C. 3rd Mortgage	053			
D. 4th Mortgage	054			
E. Other Loan	055			
F. Other Loan	056			
3. Moveable Equipment				
	061			
	062			
	063			
4. Automobiles				
	071			
	072			
	073			

Exhibit H Statement of Functional Expenses		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Nonrevenue Support Services:												
Depreciation Leases & Rental	001							2,785,914				2,785,914
Depreciation, Major Movable Equip.	002							107,230				107,230
Interest on Capital Debt	003											
Fiscal Services	004					6,998	23,552					30,550
Administrative Services	005	423,000		64,923	340,725	1,522		75,957	1,071,088			1,977,215
Plant Operation & Maint.	006	11,159		1,713		45,761	87,106		313,607			459,346
Grounds	007											
Security	008						9,653					9,653
Laundry and Linen	009	17,551		2,694		19,106	335					39,686
Housekeeping	010	319,414		49,024		54,444						422,882
Patient Food Service	011	386,857		59,376		253,174		9,904				709,311
Cafeteria	012											
Nursing Administration	013	329,105		50,353								379,458
Activities Program	014	58,408		8,965		1,336	16,069					84,778
Nonphysician Education	015											
Medical Education	016											
Medical Director's Office	017				24,009							24,009
Housing	018											
Medical Records	019	2,694		413								3,107
Utilization Review	020											
Social Service	021	56,901		8,733			1,200					66,834
Transportation	022											
TOTAL (Lines 001 thru 022)	030	1,605,089		246,194	364,734	382,341	137,915	2,979,005	1,384,695			7,099,973
Ancillary Services												
Laboratory Services	031				6,654							6,654
Electrocardiology	032											
Electroencephalogy	033											
Radiology	034						14,096					14,096
Inhalation Therapy	035											
Podiatry	036											
Dental	037				19,800							19,800
Psychiatric	038											
Physical Therapy	039	230,783		35,421	15,000	115						281,319
Occupational Therapy	040	231,250		35,493								266,743
Speech/Hearing Therapy	041	5,631		864								6,495
Pharmacy	042					177,053						177,053
Central Service Supply	043											
Medical Staff Services	044											

Exhibit H Statement of Functional Expenses (continued)		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Ancillary Other (specify below):												
	045											
	046											
	047											
TOTAL (Lines 031 thru 047)	050	467,664		71,778	41,454	177,168	14,096					772,160
Program Services												
Res. Health Care Fac.	051	1,714,274		263,269	934,422	122,241		2,690	270,115			3,307,011
Adult Care Facility	053											
I.C.F. Mental Retardation	054											
Independent Living	055											
Outpatient Clinics	057											
Home Health Care	059											
Homemaker-Services	060											
Meals on Wheels	061											
Research	062											
Physicians' Office & Other Rentals	063											
Gift Shop	064											
Public Restaurant	065											
Fund Raising	066											
Barber & Beauty Shops	067											
Sold Services	068											
Other	069											
TOTAL (Lines 051 thru 089)	090	1,714,274		263,269	934,422	122,241		2,690	270,115			3,307,011
GRAND TOTAL (Lines 030 + 050 + 090)	099	3,787,027		581,241	1,340,610	681,750	152,011	2,981,695	1,654,810			11,179,144

		Total number of employees									
Schedule P Staff Turnover RHCF		1-Jan	31-Mar	30-Jun	30-Sep	31-Dec	Full Time as of 12/31	Part Time as of 12/31	Employees retained as of 12/31, who were employed on 1/1	Employees Hired (Year)	Employees Terminated (Year)
		0770	0771	0772	0773	0774	0775	0776	0777	0778	0779
NON-CONTRACT STAFF											
RN Director of Services	001	2	2	2	2	2	2		1	1	1
Nurses with Administrative Duties	002	3	4	3	2	4	3	1	2	5	4
Registered Nurses	003										
Licensed Practical/License Vocational Nurses	004	10	10	9	13	9	4	5	6	14	15
Certified Nurse Aides	005	38	33	21	31	37	24	13	14	98	96
Total Lines 1 - 5 Employees	006	53	49	35	48	52	33	19	23	118	116
Occupational Therapists	007	8	8	8	8	8		8	3		
Occupational Therapy Assistants	008	3	3	3	3	3	2	1	3		
Occupational Therapy Aides	009										
Physical Therapists	010	3	3	3	3	3		3	3		
Physical Therapists Assistants	011	5	5	5	5	5	2	1	5		
Physical Therapy Aides	012										
Speech/Language Pathologist	013	3	5	5	5	6		6	3	3	
Respiratory Therapists	014										
Qualified Social Workers	015	2	2	1	1	2	1	1	1	1	
Other Social Services	016										
Total Lines 7 - 16 Employees	017	24	26	25	25	27	5	20	18	4	
Total Lines 6 and 17	018	77	75	60	73	79	38	39	41	122	116
CONTRACT STAFF											
RN Director of Services	019										
Nurses with Administrative Duties	020										
Registered Nurses	021										
Licensed Practical/License Vocational Nurses	022										
Certified Nurse Aides	023										
Total Lines 19 - 23 Employees	024										
Occupational Therapists	025										
Occupational Therapy Assistants	026										
Occupational Therapy Aides	027										
Physical Therapists	028										
Physical Therapists Assistants	029										
Physical Therapy Aides	030										
Speech/Language Pathologist	031										
Respiratory Therapists	032										
Qualified Social Workers	033										
Other Social Services	034										
Total Lines 25 - 34 Employees	035										
Total Lines 24 and 35	036										

Schedule 4 - Salaries And Wages		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
NonRevenue Support Services:										
Fiscal Services	004									
Administration Services	005	153,071	155,033				114,896			423,000
Plant Operation & Maint.	006	11,159								11,159
Grounds	007									
Security	008									
Laundry and Linen	009							17,551		17,551
Housekeeping	010							319,414		319,414
Patient Food Service	011	50,761	3,038					333,058		386,857
Cafeteria	012									
Nursing Administration	013	204,933	124,172							329,105
Activities Program	014	28,514						29,894		58,408
NonPhysician Education	015									
Medical Education	016									
Medical Director's Office	017									
Housing	018									
Medical Records	019						2,694			2,694
Utilization Review	020									
Social Services	021	56,901								56,901
Transportation	022									
TOTAL	030	505,339	282,243				117,590	699,917		1,605,089
Ancillary Services:										
Laboratory Services	031									
Electrocardiology	032									
Electroencephalogy	033									
Radiology	034									
Inhalation Therapy	035									
Podiatry	036									
Dental	037									
Psychiatric	038									
Physical Therapy	039	12,424	30,836			187,523				230,783
Occupational Therapy	040		78,925			152,325				231,250
Speech/Hearing Therapy	041		5,631							5,631
Pharmacy	042									
Central Service Supply	043									
Medical Staff Services	044									

Schedule 4 - Salaries And Wages (continued)		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
Ancillary Services - Other (specify below):										
	045									
	046									
	047									
TOTAL (Lines 031 thru 047)	050	12,424	115,392			339,848				467,664
Program Services:										
Res. Health Care Fac.	051			138,103	630,627	927,414	18,130			1,714,274
Adult Care Facility	053									
I.C.F. Mental Retardation	054									
Independent Living	055									
Outpatient Clinics	057									
Home Health Care	059									
Homemaker-Services	060									
Meals on Wheels	061									
Research	062									
Physicians' Office & Other Rentals	063									
Gift Shop	064									
Public Restaurant	065									
Fund Raising	066									
Barber & Beauty Shops	067									
Sold Services	068									
Other	069									
TOTAL (Lines 051 thru 089)	090			138,103	630,627	927,414	18,130			1,714,274
GRAND TOTAL (Lines 030 + 050 + 090)	099	517,763	397,635	138,103	630,627	1,267,262	135,720	699,917		3,787,027

Schedule 5 - Full Time Equivalents & Hours Paid		Number of Wks for Calculation
		0140
IMPORTANT:		
This box must be completed. Enter on line 001 the number of weeks used		
in the calculation of the columns "Hours Paid" on Schedule 5 and "Hours Worked"		
on Schedule 5A. A typical entry would be 52 wks. If the data is not for		
52 wks, enter the number of weeks included in the calculation.	001	52

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
NonRevenue Support Services:																		
Fiscal Services	004																	
Administration Services	005	1.10	2,145	0.89	1,744							1.34	2,607					3.33
Plant Operation & Maint.	006	0.29	568															0.29
Grounds	007																	
Security	008																	
Laundry and Linen	009													0.70	1,358			0.70
Housekeeping	010	1.07	2,096											10.16	19,816			11.23
Patient Food Service	011	1.09	2,116	3.21	6,266									8.75	17,053			13.05
Cafeteria	012																	
Nursing Administration	013	1.32	2,566	1.13	2,196							0.73	1,430					3.18
Activities Program	014	0.84	1,632											1.17	2,277			2.01
NonPhysician Education	015																	
Medical Education	016																	
Medical Director's Office	017																	
Housing	018																	
Medical Records	019		2,278									0.10	192					0.10
Utilization Review	020																	
Social Services	021	1.27	2,471															1.27
Transportation	022																	
TOTAL	030	6.98	15,872	5.23	10,206							2.17	4,229	20.78	40,504			35.16
Laboratory Services	031																	
Electrocardiology	032																	
Electroencephalogy	033																	
Radiology	034																	
Inhalation Therapy	035																	
Podiatry	036																	
Dental	037																	
Psychiatric	038																	
Physical Therapy	039	0.19	363	0.33	646					3.62	7,056							4.14
Occupational Therapy	040			0.84	1,635					3.00	5,848							3.84
Speech/Hearing Therapy	041			0.06	123													0.06
Pharmacy	042																	
Central Service Supply	043																	
Medical Staff Services	044																	

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
Ancillary Services - Other																		
(specify below):																		
	045																	
	046																	
	047																	
TOTAL (Lines 031 thru 047)	050	0.19	363	1.23	2,404					6.62	12,904							8.04
Res. Health Care Fac.	051					1.80	3,517	10.90	21,251	28.58	55,738	0.73	1,430					42.01
Adult Care Facility	053																	
I.C.F. Mental Retardation	054																	
Independent Living	055																	
Outpatient Clinics	057																	
Home Health Care	059																	
Homemaker-Services	060																	
Meals on Wheels	061																	
Research	062																	
Physicians' Office & Other	063																	
Gift Shop	064																	
Public Restaurant	065																	
Fund Raising	066																	
Barber & Beauty Shops	067																	
Sold Services	068																	
Other	069																	
TOTAL (Lines 051 thru 089)	090					1.80	3,517	10.90	21,251	28.58	55,738	0.73	1,430					42.01
GRAND TOTAL																		
(Lines 030 + 050 + 090)	099	7.17	16,235	6.46	12,610	1.80	3,517	10.90	21,251	35.20	68,642	2.90	5,659	20.78	40,504			85.21

EXHIBIT 65

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue		RHCF	Revenue - Other	Total
		0463	0160	0161
Analysis of Total Operating Revenue				
Medicaid Net Revenue				
A. Social Services	011	6,110,510		6,110,510
B. Managed Care Provider	025	615,511		615,511
C. Other Services	012			
TOTAL MEDICAID NET REVENUE	001	6,726,021		6,726,021
Medicare Net Revenue				
A. Part A - All Income	002	1,865,527		1,865,527
B Part B - Income	003	154,797		154,797
C. Part B - Final Settlement	004			
D. Managed Care Provider	026			
TOTAL MEDICARE NET REVENUE	013	2,020,324		2,020,324
Private Patient Revenue	005	1,046,840		1,046,840
Other Net Patient Revenue	006	1,008,907		1,008,907
TOTAL NET PATIENT REVENUE	010	10,802,092		10,802,092
All Other Operating Revenue*	015	2,545,806		2,545,806
TOTAL OPERATING REVENUE	020	13,347,898		13,347,898

*Line 0015 Column 00160 would be used for reporting revenue for all other operating revenue centers.

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue (continued)		Blue Cross	Travelers	Other
		0243	0244	0245
Part B Cash Receipts By Intermediary				
For Report Year	021			154,797
For Prior Year	022			
All Other Years	023			
TOTAL	030			154,797

Schedule 9 - Property Expenses (All Property Expenses Must be Reported on This Schedule)		Amount	Cost Center Line No. Affected
		0270	0271
Building/Fixed Equipment:			
Depreciation - Owned Assets	001		001
Depreciation - Captitalized Assets	002		001
Interest - Mortgage(s)	003		003
Interest - Capitalized Leases	004		003
Rent	005	2,680,000	001
Property Insurance	006	10,832	005
Boiler Insurance	007		
	008		
	009		
	010		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	011		
Interest - Mortgages	012		
Amortization	013		
TOTAL (Lines 001 thru 013)	015	2,690,832	
Land/Leasehold Improvements:			
Depreciation - Owned Assets	016		001
Depreciation - Capitalized Leases	017		001
Amortization	018	12,730	001
Interest - Owned Assets	019		003
Interest - Capitalized Leases	020		003
Rent	021		001
	022		
	025		
	026		
SPRINKLERS(Accelerated Project Financing Only)			
Depreciation	027		
Interest - Mortgages	028		
Amortization	029		
TOTAL (Lines 016 thru 022 + 025 thru 029)	031	12,730	
Moveable Equipment:			
Depreciation - Owned Assets	032	55,680	002
Depreciation - Capitalized Leases	033		002
Interest - Mortgage(s)	034		003
Interest - Capitalized Leases	035		003
Interest - Other	036		
Equipment Rent A	037	60,445	005
Equipment Rent B	038	5,342	051
Equipment Rent C	039		
Equipment Rent D	040		
Equipment Rent E	041		
Equipment Rent F	042		
Equipment Rent G	043		
Equipment Rent H	044		
Equipment Rent I	045		
Equipment Rent J	046		
Equipment Rent K	047		
Equipment Rent L	048		
Equipment Rent M	049		
Equipment Rent N	050		
Equipment Rent O	051		
Equipment Rent P	052		
Equipment Rent Q	053		
Equipment Rent R	054		
Equipment Rent S	055		
Equipment Rent T	056		
Equipment Rent U	057		
Equipment Rent V	058		
Equipment Rent W	059		
Equipment Rent X	060		
Equipment Rent Y	061		
Equipment Rent Z	062		
Computer Equipment Rent	063		
TOTAL Rental (Lines 37 thru 63)	096	65,787	
Auto Insurance	064	3,125	005
Rent: All Capitalized Leases (Sch. 9A)	065		
	067		
TOTAL (Lines 032 thru 067)	070	124,592	
Other:			
Sales Tax	071	29,674	005
Real Estate Taxes	023	148,282	006
Payments in lieu of Taxes	094		006
Occupancy Taxes	024		006
Mortgage Insurance Premium	072		
Fees & Charges: 28A Fees	073		005
Fees: Outside PRI Assessor	074		
Other Fees (Specify):			
	075		
Amortization - Mortgage Expense	076		
Amortization - Organization Expense	077	2,000	005
Amortization - Legal Expense	078		005
Nurse Aide Training Costs	079		
Nurse Aide Testing Costs	080		
NYS Revenue Assessment	081	414,392	005
Bad Debts	082	210,363	005
Telephone Equipment - Depreciation	091		
Telephone Equipment - Interest	092		
Telephone Equipment - Rental	093		
	083		
	084		
	085		

Exhibit H Statement of Functional Expenses		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Nonrevenue Support Services:												
Depreciation Leases & Rental	001							2,692,730				2,692,730
Depreciation, Major Movable Equip.	002							55,680				55,680
Interest on Capital Debt	003											
Fiscal Services	004					7,221						7,221
Administrative Services	005	353,709		54,837	1,099,936	2,663		60,445	1,526,176			3,097,766
Plant Operation & Maint.	006	31,080		4,818		20,183	111,783		304,094			471,958
Grounds	007											
Security	008						28,809					28,809
Laundry and Linen	009	21,168		3,282		33,104	290					57,844
Housekeeping	010	279,310		43,302		53,829						376,441
Patient Food Service	011	395,215		61,271		331,845	51,545		3,194			843,070
Cafeteria	012											
Nursing Administration	013	270,327		41,910								312,237
Activities Program	014	82,095		12,727		5,831	14,975					115,628
Nonphysician Education	015											
Medical Education	016											
Medical Director's Office	017				24,009							24,009
Housing	018											
Medical Records	019					170						170
Utilization Review	020											
Social Service	021	75,544		11,712			400					87,656
Transportation	022											
TOTAL (Lines 001 thru 022)	030	1,508,448		233,859	1,123,945	454,846	207,802	2,808,855	1,833,464			8,171,219
Ancillary Services												
Laboratory Services	031				17,418							17,418
Electrocardiology	032											
Electroencephalogy	033											
Radiology	034						9,095					9,095
Inhalation Therapy	035											
Podiatry	036											
Dental	037				22,140							22,140
Psychiatric	038											
Physical Therapy	039	264,787		41,051	15,162	-407	-5,000					315,593
Occupational Therapy	040	194,820		30,204								225,024
Speech/Hearing Therapy	041	22,224		3,445								25,669
Pharmacy	042					228,638						228,638
Central Service Supply	043											
Medical Staff Services	044											

Exhibit H Statement of Functional Expenses (continued)		Salaries & Wages	Physicians Remuneration	Employee Benefits	Fees(1)	Supplies and Material	Purchased and Contracted Services	Deprec. Leases & Rentals	Other Direct Expense	Assessments	Transfers	Totals
		0034	0035	0036	0037	0038	0039	0040	0041	0042	0043	0044
Ancillary Other (specify below):												
	045											
	046											
	047											
TOTAL (Lines 031 thru 047)	050	481,831		74,700	54,720	228,231	4,095					843,577
Program Services												
Res. Health Care Fac.	051	2,035,708		315,602	1,368,083	122,814		5,432	2,056			3,849,695
Adult Care Facility	053											
I.C.F. Mental Retardation	054											
Independent Living	055											
Outpatient Clinics	057											
Home Health Care	059											
Homemaker-Services	060											
Meals on Wheels	061											
Research	062											
Physicians' Office & Other Rentals	063											
Gift Shop	064											
Public Restaurant	065											
Fund Raising	066											
Barber & Beauty Shops	067											
Sold Services	068											
Other	069											
TOTAL (Lines 051 thru 089)	090	2,035,708		315,602	1,368,083	122,814		5,432	2,056			3,849,695
GRAND TOTAL (Lines 030 + 050 + 090)	099	4,025,987		624,161	2,546,748	805,891	211,897	2,814,287	1,835,520			12,864,491

Schedule P Staff Turnover RHCF		Total number of employees									
		1-Jan	31-Mar	30-Jun	30-Sep	31-Dec	Full Time as of 12/31	Part Time as of 12/31	Employees retained as of 12/31, who were employed on 1/1	Employees Hired (Year)	Employees Terminated (Year)
		0770	0771	0772	0773	0774	0775	0776	0777	0778	0779
NON-CONTRACT STAFF											
RN Director of Services	001	2	1	1	1	1	1		1		1
Nurses with Administrative Duties	002		3	3	1	2	2	2		3	3
Registered Nurses	003	2	3	2	4	3	1			6	5
Licensed Practical/License Vocational Nurses	004	6	7	5	6	7	2	5	3	11	9
Certified Nurse Aides	005	36	42	36	30	36	13	23	15	123	123
Total Lines 1 - 5 Employees	006	46	56	47	42	49	19	30	19	143	141
Occupational Therapists	007	8	9	9	9	9		9	8	1	
Occupational Therapy Assistants	008	3	2	2	2	2	2		2		1
Occupational Therapy Aides	009										
Physical Therapists	010	3	2	3	3	3	1	2	2	1	1
Physical Therapists Assistants	011	4	5	5	5	5	2	3	4	1	
Physical Therapy Aides	012										
Speech/Language Pathologist	013	6	2	2	2	2		2	2		4
Respiratory Therapists	014										
Qualified Social Workers	015	2	2	2	2	2	2		2		
Other Social Services	016										
Total Lines 7 - 16 Employees	017	26	22	23	23	23	7	16	20	3	6
Total Lines 6 and 17	018	72	78	70	65	72	26	46	39	146	147
CONTRACT STAFF											
RN Director of Services	019										
Nurses with Administrative Duties	020										
Registered Nurses	021										
Licensed Practical/License Vocational Nurses	022										
Certified Nurse Aides	023										
Total Lines 19 - 23 Employees	024										
Occupational Therapists	025										
Occupational Therapy Assistants	026										
Occupational Therapy Aides	027										
Physical Therapists	028										
Physical Therapists Assistants	029										
Physical Therapy Aides	030										
Speech/Language Pathologist	031										
Respiratory Therapists	032										
Qualified Social Workers	033										
Other Social Services	034										
Total Lines 25 - 34 Employees	035										
Total Lines 24 and 35	036										

Schedule 4 - Salaries And Wages		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
NonRevenue Support Services:										
Fiscal Services	004									
Administration Services	005	165,687	66,211				121,811			353,709
Plant Operation & Maint.	006	31,080								31,080
Grounds	007									
Security	008									
Laundry and Linen	009							21,168		21,168
Housekeeping	010							279,310		279,310
Patient Food Service	011	44,534						350,681		395,215
Cafeteria	012									
Nursing Administration	013	143,497	112,100				14,730			270,327
Activities Program	014	36,708				45,387				82,095
NonPhysician Education	015									
Medical Education	016									
Medical Director's Office	017									
Housing	018									
Medical Records	019									
Utilization Review	020									
Social Services	021	75,544								75,544
Transportation	022									
TOTAL	030	497,050	178,311			45,387	136,541	651,159		1,508,448
Ancillary Services:										
Laboratory Services	031									
Electrocardiology	032									
Electroencephalogy	033									
Radiology	034									
Inhalation Therapy	035									
Podiatry	036									
Dental	037									
Psychiatric	038									
Physical Therapy	039	60,409	45,791			158,587				264,787
Occupational Therapy	040		77,950			116,870				194,820
Speech/Hearing Therapy	041		22,224							22,224
Pharmacy	042									
Central Service Supply	043									
Medical Staff Services	044									

Schedule 4 - Salaries And Wages (continued)		Management & Supervision	Tech Specs & Non-Physician Medical Pracs	Registered Nurses	Licensed Practical Nurses	Aides Orderlies & Assistants	Clerical & Other Admin Employees	Environment Hotel & Food Service	Interns Residents & Fellows	Total Salaries and Wages
		0114	0115	0116	0117	0118	0119	0120	0121	0122
Ancillary Services - Other (specify below):										
	045									
	046									
	047									
TOTAL (Lines 031 thru 047)	050	60,409	145,965			275,457				481,831
Program Services:										
Res. Health Care Fac.	051			81,728	766,103	1,187,877				2,035,708
Adult Care Facility	053									
I.C.F. Mental Retardation	054									
Independent Living	055									
Outpatient Clinics	057									
Home Health Care	059									
Homemaker-Services	060									
Meals on Wheels	061									
Research	062									
Physicians' Office & Other Rentals	063									
Gift Shop	064									
Public Restaurant	065									
Fund Raising	066									
Barber & Beauty Shops	067									
Sold Services	068									
Other	069									
TOTAL (Lines 051 thru 089)	090			81,728	766,103	1,187,877				2,035,708
GRAND TOTAL (Lines 030 + 050 + 090)	099	557,459	324,276	81,728	766,103	1,508,721	136,541	651,159		4,025,987

Schedule 5 - Full Time Equivalents & Hours Paid		Number of Wks for Calculation
		0140
IMPORTANT:		
This box must be completed. Enter on line 001 the number of weeks used		
in the calculation of the columns "Hours Paid" on Schedule 5 and "Hours Worked"		
on Schedule 5A. A typical entry would be 52 wks. If the data is not for		
52 wks, enter the number of weeks included in the calculation.	001	52

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
NonRevenue Support Services:																		
Fiscal Services	004																	
Administration Services	005	1.07	2,088	1.07	2,088							2.58	5,035					4.72
Plant Operation & Maint.	006	0.63	1,224															0.63
Grounds	007																	
Security	008																	
Laundry and Linen	009													0.59	1,156			0.59
Housekeeping	010													9.83	19,165			9.83
Patient Food Service	011	1.07	2,088											12.36	24,097			13.43
Cafeteria	012																	
Nursing Administration	013	1.82	3,544	2.78	5,424							0.85	1,660					5.45
Activities Program	014	1.07	2,096							1.86	3,623							2.93
NonPhysician Education	015																	
Medical Education	016																	
Medical Director's Office	017																	
Housing	018																	
Medical Records	019																	
Utilization Review	020																	
Social Services	021	1.88	3,675															1.88
Transportation	022																	
TOTAL	030	7.54	14,715	3.85	7,512					1.86	3,623	3.43	6,695	22.78	44,418			39.46
Laboratory Services	031																	
Electrocardiology	032																	
Electroencephalogy	033																	
Radiology	034																	
Inhalation Therapy	035																	
Podiatry	036																	
Dental	037																	
Psychiatric	038																	
Physical Therapy	039	1.07	2,080	0.61	1,197					2.97	5,796							4.65
Occupational Therapy	040			0.83	1,618					2.09	4,066							2.92
Speech/Hearing Therapy	041			0.25	490													0.25
Pharmacy	042																	
Central Service Supply	043																	
Medical Staff Services	044																	

		Management & Supervision		Tech Specs & Non-Physician Medical Pracs		Registered Nurses		Licensed Practical Nurses		Aides Orderlies & Assistants		Clerical & Other Admin Employees		Environment Hotel & Food Service		Interns Residents & Fellows		Total
Schedule 5 -		FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE	HRS PD	FTE's
		0123	0124	0125	0126	0127	0128	0129	0130	0131	0132	0133	0134	0135	0136	0137	0138	0139
Ancillary Services - Other																		
(specify below):																		
	045																	
	046																	
	047																	
TOTAL (Lines 031 thru 047)	050	1.07	2,080	1.69	3,305					5.06	9,862							7.82
Res. Health Care Fac.	051					0.59	1,157	10.15	19,784	37.48	73,088							48.22
Adult Care Facility	053																	
I.C.F. Mental Retardation	054																	
Independent Living	055																	
Outpatient Clinics	057																	
Home Health Care	059																	
Homemaker-Services	060																	
Meals on Wheels	061																	
Research	062																	
Physicians' Office & Other	063																	
Gift Shop	064																	
Public Restaurant	065																	
Fund Raising	066																	
Barber & Beauty Shops	067																	
Sold Services	068																	
Other	069																	
TOTAL (Lines 051 thru 089)	090					0.59	1,157	10.15	19,784	37.48	73,088							48.22
GRAND TOTAL																		
(Lines 030 + 050 + 090)	099	8.61	16,795	5.54	10,817	0.59	1,157	10.15	19,784	44.40	86,573	3.43	6,695	22.78	44,418			95.50

EXHIBIT 66

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. BUILDING B. WING _____	04/29/2020

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

(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) COMPLETE DATE
F 000	INITIAL COMMENTS A COVID-19 Infection Control Focus Survey was conducted at The Villages of Orleans Health and Rehabilitation Center 4/29/20 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. As a result of this survey, the facility was determined to be in compliance with these requirements.	F 000		

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

EXHIBIT 67

New York State Department of Health
Bureau of Long Term Care Reimbursement
Division of Finance and Rate Setting

Oct 12, 2021 8:58 AM

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Nursing Home Certification Submission System

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
RHCF-4 (4/06) DOH-490

FACILITY: Comprehensive at Orleans

OPERATING CERTIFICATE NUMBER: 3620301N

REPORT FOR THE PERIOD ENDED: 12/31/2015

DECLARATION CONTROL NUMBER (DCN): 61871556

Operators Certification

The following statement must be read and a certification of such be signed pursuant to Part 86-2.6(a). This subpart states "The Financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary facility or the public official responsible for the operation of a public medical facility". Please enter only one signature.

Certification Statement

Misrepresentation or falsification of any information contained on this form may be punishable by fine and / or imprisonment under New York State Law and Federal Law.

Certification of Operator

I hereby certify that I am the Operator and have read the above statement and I have examined and compared the information contained in the RHCF -4 report file with the information provided in my electronically transmitted Department of Health file, DCN identified above, and that to the best of my knowledge and belief, they are true and complete and that these files are identical.

I also certify that Parts I and II were completed in accordance with the RHCF - 4 instructions and that Part IV was completed in accordance with the residential Health Care Facility Accounting and Reporting Manual (RHCFARM). I also certify, the Part(s) III, if required to be filed as part of this report, was (were) completed in accordance with RHCFARM and the information called for in Part III has been reported for each lender or organization related to the provider as defined in Schedule 16 of Part II.

I also certify that all salary and non-salary expenses presented in the RHCF - 4 (with the exception of those expenses attributable to Research, Physicians Offices and other Rentals, Gift Shop, Public Restaurant, Fund Raising and Sold Services) considering the adjustments contained in the Part II and the recoveries of expense detailed in Exhibit I of the Part IV were incurred to provide patient care in the facility.

JUL 13 2016 06:35:49 AM	villags1
Date	Signature
	Sam Halper
	Operator

DOH 490 (4/06)

*** * * * End of Certification * * * ***

DCN 61871556 was previously certified by HCS ID villags1,

Sam Halper , Operator for Comprehensive at Orleans.

Continue

Nursing Home Cost Report Main Page

New York State Department of Health
Bureau of Long Term Care Reimbursement
Division of Finance and Rate Setting

Oct 13, 2021 9:55 AM

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Nursing Home Certification Submission System

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
RHCF-4 (4/06) DOH-490

FACILITY: Comprehensive at Orleans

OPERATING CERTIFICATE NUMBER: 3620301N

REPORT FOR THE PERIOD ENDED: 12/31/2016

DECLARATION CONTROL NUMBER (DCN): 71811104

Operators Certification

The following statement must be read and a certification of such be signed pursuant to Part 86-2.6(a). This subpart states "The Financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary facility or the public official responsible for the operation of a public medical facility". Please enter only one signature.

Certification Statement

Misrepresentation or falsification of any information contained on this form may be punishable by fine and / or imprisonment under New York State Law and Federal Law.

Certification of Operator

I hereby certify that I am the Operator and have read the above statement and I have examined and compared the information contained in the RHCF -4 report file with the information provided in my electronically transmitted Department of Health file, DCN identified above, and that to the best of my knowledge and belief, they are true and complete and that these files are identical.

I also certify that Parts I and II were completed in accordance with the RHCF - 4 instructions and that Part IV was completed in accordance with the residential Health Care Facility Accounting and Reporting Manual (RHCFARM). I also certify, the Part(s) III, if required to be filed as part of this report, was (were) completed in accordance with RHCFARM and the information called for in Part III has been reported for each lender or organization related to the provider as defined in Schedule 16 of Part II.

I also certify that all salary and non-salary expenses presented in the RHCF - 4 (with the exception of those expenses attributable to Research, Physicians Offices and other Rentals, Gift Shop, Public Restaurant, Fund Raising and Sold Services) considering the adjustments contained in the Part II and the recoveries of expense detailed in Exhibit I of the Part IV were incurred to provide patient care in the facility.

JUN 30 2017 11:15:38 AM	villags1
Date	Signature
	Sam Halper
	Operator

DOH 490 (4/06)

*** * * * End of Certification * * * ***

DCN 71811104 was previously certified by HCS ID villags1,

Sam Halper , Operator for Comprehensive at Orleans.

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New York State Department of Health
Bureau of Long Term Care Reimbursement
Division of Finance and Rate Setting

Oct 15, 2021 8:23 AM

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Nursing Home Certification Submission System

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
RHCF-4 (4/06) DOH-490

FACILITY: Comprehensive at Orleans

OPERATING CERTIFICATE NUMBER: 3620301N

REPORT FOR THE PERIOD ENDED: 12/31/2017

DECLARATION CONTROL NUMBER (DCN): 81941106

Operators Certification

The following statement must be read and a certification of such be signed pursuant to Part 86-2.6(a). This subpart states "The Financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary facility or the public official responsible for the operation of a public medical facility". Please enter only one signature.

Certification Statement

Misrepresentation or falsification of any information contained on this form may be punishable by fine and / or imprisonment under New York State Law and Federal Law.

Certification of Operator

I hereby certify that I am the Operator and have read the above statement and I have examined and compared the information contained in the RHCF -4 report file with the information provided in my electronically transmitted Department of Health file, DCN identified above, and that to the best of my knowledge and belief, they are true and complete and that these files are identical.

I also certify that Parts I and II were completed in accordance with the RHCF - 4 instructions and that Part IV was completed in accordance with the residential Health Care Facility Accounting and Reporting Manual (RHCFARM). I also certify, the Part(s) III, if required to be filed as part of this report, was (were) completed in accordance with RHCFARM and the information called for in Part III has been reported for each lender or organization related to the provider as defined in Schedule 16 of Part II.

I also certify that all salary and non-salary expenses presented in the RHCF - 4 (with the exception of those expenses attributable to Research, Physicians Offices and other Rentals, Gift Shop, Public Restaurant, Fund Raising and Sold Services) considering the adjustments contained in the Part II and the recoveries of expense detailed in Exhibit I of the Part IV were incurred to provide patient care in the facility.

JUL 15 2018 07:13:59 PM	villags1
Date	Signature
	Sam Halper
	Operator

DOH 490 (4/06)

*** * * * End of Certification * * * ***

DCN 81941106 was previously certified by HCS ID villags1,

Sam Halper , Operator for Comprehensive at Orleans.

Continue

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