

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER The Villages of Orleans Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14012 Route 31 Albion, NY 14411	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER The Villages of Orleans Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14012 Route 31 Albion, NY 14411	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during an Abbreviated survey (#2604865) the facility did not ensure each resident receives adequate supervision to prevent elopement for one (1) (Resident #1) of three (3) residents reviewed for elopement. Specifically, the facility discontinued Resident #1's wander guard on 08/20/2025, the facility did not implement additional care plan interventions after the removal of a wander guard (device that alarms if the resident leaves a designated area). The resident did not have a physicians order to go out on pass and left the facility on [DATE] with a staff member, Housekeeper #1. The finding is: The policy titled Elopement/Missing Resident dated 07/2024 documented patients/residents identified at risk to elope will have an individualized interdisciplinary plan of care. Exit seeking behavior may include but not limited to history of elopement, opening doors to outside, making statements referencing leaving the facility, seeking to find someone/something outside the facility, and noncompliance with facility protocols. The policy titled Resident Out on Pass - Social Leave of Absence dated 09/2011, documented the resident must have an active resident may go out on pass with responsible party order from the provider. The responsible party will sign the resident out, indicating who they are taking out (which resident), the time they are leaving the facility, destination, and anticipated time of return along with a signature. Resident #1 had diagnoses including diabetes mellitus (high blood sugar levels), vascular dementia (type of dementia caused by reduced blood flow to the brain), and schizoaffective disorder bipolar type (mental health condition). The Minimum Data Set (a resident assessment tool) dated 07/10/2025 documented the resident was moderately cognitively impaired and required supervision or touching assistance with transfers and ambulation. The comprehensive care plan documented Resident #1 was an elopement risk/wanderer related to history of attempts to leave facility and had poor safety awareness which was documented as initiated on 03/03/2025. The comprehensive care plan had documented to verify placement of the wander guard bracelet under wheelchair every shift which was discontinued on 08/20/2025. There were no additional interventions initiated to the elopement risk/wanderer care plan 08/20/2025 through 08/28/2025. The Health Care Proxy - Decision-Making Capacity Determination, signed and dated 01/30/2025 by the medical provider, documented the resident lacked capacity to make their own medical decisions. The Wandering Risk evaluation dated 07/08/2025 documented the resident was at moderate risk of wandering. The Progress Note completed by Licensed Practical Nurse Unit Manager #1 signed and dated 08/20/2025 4:40 PM documented Resident #1 had removed the wander guard bracelet from their ankle twice and removed the bracelet from the wheelchair once. Resident #1 declined to have the wander guard bracelet applied to their person or chair stating they would remove it again. The note documented Resident #1 had not made any recent attempts or voiced wanting to leave the facility. The wander guard was removed from physician orders and care, and the resident remained an elopement risk. The progress note did not document any additional preventative interventions or increased monitoring. Review of the physician orders 08/01/2025 - 08/30/2025 did not include the order Resident #1 may go out on pass with responsible party. The facility Nursing Home Facility Incident Report dated 08/29/2025 documented on 08/29/2025 at approximately 5:00 PM Resident #1 left the facility with Housekeeper #1. Housekeeper #1 drove the resident to the resident's hometown and arrived at the responsible party's house approximately 45 minutes away from the facility. During an observation on 11/13/2025 at 9:49 AM, Resident #1 was observed well kempt, self-propelling their wheelchair in a common area. The resident asked if the surveyor knew there a particular street was and if they could give them a ride there later. During telephone interview on 11/13/2025 at 10:25 AM, Resident #1's responsible party stated Resident #1 came to their home unexpectedly on 08/29/2025 at approximately 5:45 PM accompanied by a person unknown to the responsible party. The responsible party contacted an acquaintance that worked at the facility to come get Resident #1. During an interview on 11/13/2025 at 10:45 AM, Licensed Practical Nurse #2 stated they received a telephone call from Resident #1's responsible party on 08/29/2025 at approximately 6:00 PM. Licensed Practical Nurse #2 went to the responsible parties home and encouraged Resident #1 to return to the facility. During an interview on 11/13/2025 at 11:48 AM, the Director of Nursing stated Licensed Practical Nurse #2 called them on 08/29/2025 at approximately 6:15 PM- 6:30 PM to report Housekeeper #1 had driven Resident #1 to their responsible party's house. The Director of Nursing stated they immediately sent out a facility wide alert at 6:27 PM that Resident #1 had eloped from the facility. Additionally, they stated no care plan interventions were initiated when the wander guard bracelet was</p>		