STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335090	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Church Manor Nursing Home	863 Front Street Binghamton, NY 13905

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37516 Based on observation, record review, and interviews, during the abbreviated survey (NY00354300) the facility failed to ensure residents remained as free of accident hazards as possible for 7 of 55 residents (Residents #1, #4, #5, #6, #7, #8 and #9) reviewed. Specifically, Resident #1 who had severely impaired cognition, had a contour mattress and right side bed rail (assist rail) and was not assessed for appropriate alternatives to the bed rail, was not assessed for entrapment risk, did not have the risks and benefits of a bed rail reviewed, and there was no informed consent from the resident's representative before installation of the bed rail. Subsequently, the resident was found with their body out of the bed and their head wedged between the bed rail and the mattress and was pronounced deceased . Additionally, Residents #4, #5, #6, #8, and #9 had multiple risk factors identified on their bed rail assessments and were recommended to have bed rails applied; Residents #4, #5, #6, #7, and #8 did not have risks and benefits of bed rails reviewed with them or their representatives and did not have informed consent prior to the use of bed rails. This resulted in Immediate Jeopardy to Resident #1 and placed all residents with bed rails at risk for the likelihood of serious harm, serious impairment, serious injury, or death (Refer to F 700). See heading titled Bed Rail Assessments. Based on record review and interviews during the abbreviated survey (NY00354147) the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 of 3 residents (Residents #16 and #17) reviewed. Specifically, Resident #17, who had severely impaired cognition and known wandering behaviors, exited the building undetected by staff, crossed the road to a gas station, and remained away from the facility for over 40 minutes before their whereabouts was reported to the facility. Additionally, Resident #16 who had severely impaired cognition and a history of wandering behavior, was observed by staff who were walking through the lobby, exiting the front lobby door in their wheelchair. This resulted in Immediate Jeopardy to Resident #17 and placed all residents with exit-seeking behaviors at risk for serious harm, serious injury, serious impairment, or death. See heading titled Elopement. Findings include: Bed Rail Assessments (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The job description for Registered Nurse Assessment Nurse signed by Assessment Registered Nurse #9 on [DATE], documented essential functions and requirements included completing the nursing assessment, pressure ulcer risk assessment, fall risk assessment, pain assessment, physical restraint determination and the elopement risk assessment at intervals; assist in the care plan process in conjunction with the Interdisciplinary Team to ensure appropriate treatments and/or interventions were implemented according to resident need and physician orders; perform assessments in relationship to change in resident status; communicate effectively with residents and families; current knowledge and practice of accepted standards of professional nursing practice; and, awareness of environmental safety. On [DATE] the facility provided a list of 54 residents in the facility who currently had bed rails on their beds. 1) Resident #1 had diagnoses including Alzheimer's disease, epilepsy (a seizure disorder), and unsteadiness on their feet. The [DATE] Minimum Data Set Assessment documented the resident had severely impaired cognition, required partial to moderate assistance for rolling left to right and sitting on the side of the bed, required supervision, or touching assistance to stand and for chair/bed to chair transfer, and did not use bed rails. A [DATE] Bed Rail Assessment (using the facility's former Bed Rail Assessment tool) completed by Assessment Registered Nurse #39 documented the risks and benefits of bed rails were discussed with the resident representative and verbal consent was given by the resident representative for the use of bilateral bed rails. Alternatives to bed rail use and restraint determination areas on the assessment tool were not documented. The Comprehensive Care Plan, initiated [DATE], documented the resident had activities of daily living self-care performance deficits related to confusion, dementia, and chronic pain. Interventions included the resident required extensive assistance to turn and reposition in bed, and limited assistance for transfers. The resident was at moderate risk for falls related to confusion and lack of safety awareness. Interventions included keep bed at knee height when the resident was in bed, and frequent safety checks while in bed. There was no documentation the resident had a right side bed rail, contoured mattress, or that the left side of the bed was against the wall. A [DATE] Physical Therapist #44 progress note documented the resident performed bed mobility sit to supine and supine to sit using a right side bed rail requiring stand by assistance. The resident benefited from verbal/tactile cues for sequencing and technique. An [DATE] Bed Rail Assessment documented the resident's level of consciousness fluctuated, they had an alteration in safety awareness due to cognitive decline, had a history of falls, displayed poor bed mobility, and had difficulty with balance or poor trunk control. Interventions included to provide frequent staff monitoring at night and provide assisted toileting at night. Bed rail recommendations were for a right side bed rail to serve as an enabler to promote independence. The resident/responsible party signature and date block documented verbal [DATE] and was signed off by Assessment Registered Nurse #9. There was no documentation the risks and benefits of a right side bed rail were discussed, or that informed consent was given for the use of a right side bed rail by the resident's representative. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A [DATE] facility incident report documented the resident was last observed at 4:30 AM during incontinence care. At 5:45 AM when Licensed Practical Nurse #4 came into the resident's room to administer medications, they observed the resident with their head and neck wedged between the right side bed rail and mattress. After assessment by Registered Nurse #3 the resident was pronounced dead. Resident #1's death certificate documented the resident expired on [DATE] at 5:45 AM and the immediate cause of death was listed as probable positional asphyxia (a body position that prevented normal breathing). The resident care instructions as of [DATE] documented the resident's bed was kept at knee height, they required frequent safety checks while in bed, required limited assistance for transfers, and used a rolling walker to maximize independence with transferring. There was documentation of the use of a right side bed rail. During an observation on [DATE] at 10:14 AM Resident #1's left side of the bed was against the wall and a bed rail was attached to the right side of the bed. During an interview on [DATE] at 10:00 AM the Director of Therapy stated bed rail use required a nursing assessment for the ability to use the bed rail correctly and safely. They thought maintenance was responsible for the installation of bed rails at the request of nursing and was unsure if therapy ever requested bed rails. Bed rails caused a risk for entrapment and were not used to prevent falling from bed. They stated Resident #1 received therapy to improve transfer safety, but therapy had taken place in the gym, not in the resident's room, so they had not assessed Resident #1 for bed rail use. During an interview on [DATE] at 1:18 PM, the Administrator stated bed rail use was determined by an assessment, generally at the request of the resident or family member. (Refer to F700) During an interview on [DATE] at 9:48 AM Registered Nurse Unit Manager #10 stated the resident had been using the right side bed rail to stand, pivot, and transfer from their bed into their wheelchair. During a telephone interview on [DATE] at 3:16 PM Resident #1's Representative stated they did not know the resident had a bed rail and they did not recall facility staff ever calling them to discuss the risks and benefits of a bed rail. They would remember something like that. When they went to the facility to pick up some items from Resident #1's room on [DATE] they were surprised to see a bed rail on the bed. 2) Resident #4 had diagnoses including Alzheimer's disease and Parkinson's disease (a progressive neurological disorder). The [DATE] Minimum Data Set Assessment documented the resident had intact cognition, impaired vision, and required partial to moderate assistance for rolling left to right, lying to sitting on side of bed, sitting to standing and chair/bed to chair transfers, and did not use bed rails. The Comprehensive Care Plan, initiated on [DATE], documented the resident had activities of daily living decline. Interventions included extensive assistance of one to turn and reposition in bed, and right and left bed rails to facilitate independent position changes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The [DATE] Bed Rail Assessment documented the resident's level of consciousness fluctuated, they had an alteration in safety awareness due to cognitive decline, had a history of falls, displayed poor bed mobility, had difficulty with balance or poor trunk control and was visually challenged. Interventions included provide assisted toileting for the resident at night and visual and verbal reminders to use the call bell. Bed rail recommendations were for bilateral rails to serve as an enabler to promote independence. The resident/responsible party signature and date block documented verbal and was signed off by Assessment Registered Nurse #9. There was no documentation the risks and benefits of bed rails were discussed, or that informed consent was given for the bed rails. During an observation on [DATE] the resident's bed had bilateral bed rails with the right side of the bed against the wall. Resident care instructions as of [DATE] documented the resident had right and left bed rails as assistive devices to facilitate independent position changes. During an interview on [DATE] at 2:18 PM Resident #4's Representative stated the resident had the bed rails for a long time. They did not recall if the risks or benefits of bed rails were discussed with them prior to installation or when they may have given informed consent. The [DATE] updated Bed Rail Assessment by Registered Nurse Unit Manager #19 documented bed rail use was not indicated, and the bed rails were removed. There was no physical restraint assessment documented for the right side of the bed against the wall with a contoured mattress until [DATE] by the Assistant Director of Nursing. 3) Resident #5 had diagnoses including Alzheimer's disease. The [DATE] Minimum Data Set Assessment documented the resident had severely impaired cognition, required partial to moderate assistance for rolling left to right, lying to sitting on side of the bed, sitting to standing and chair/bed-to-chair transfers, and did not use bed rails. The Comprehensive Care Plan, initiated on [DATE], documented the resident had an activities of daily living self-care performance deficit related to limited mobility. Interventions included extensive assistance of one to turn and reposition in bed, the left side of the bed was against the wall per resident preference, and they had a contoured mattress. There was no documentation the resident had a right side bed rail. The [DATE] Bed Rail Assessment documented the resident's level of consciousness fluctuated, they had an alteration in safety awareness due to cognitive decline, displayed poor bed mobility and had difficulty with balance or poor trunk control. Interventions included provide assisted toileting for the resident at night and visual and verbal reminders to use the call bell. Bed rail recommendations were for a right side bed rail to serve as an enabler to promote independence. The resident/responsible party signature and date block documented verbal [DATE] and was signed off by Assessment Registered Nurse #9. There was no documentation the risks and benefits of bed rails were discussed, or that informed consent was given for the bed rail. During an observation on [DATE] the resident's bed had a right side bed rail, and the left side of the bed was against the wall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The resident care instructions on [DATE] did not document the use of a right side bed rail. The [DATE] at 4:55 PM updated Bed Rail Assessment by the Assistant Director of Nursing documented bed rails were not indicated, and the right side bed rail was removed. There was no physical restraint assessment documented for the left side of the bed against the wall with a contoured mattress until [DATE] by Registered Nurse Unit Manager #26. During an interview on [DATE] at 10:07 AM Assessment Registered Nurse #9 stated if a new admission entered the facility and the bed, they were in already had bed rails attached, they would do a bed rail assessment at that moment to see if the resident could use them appropriately. They were not aware of any other interventions trialed first on Resident #1 before the right side bed rail was recommended, and they were not aware of the resident's family or representative requesting a bed rail. When they did bed rail assessments, they went into the resident rooms to observe the bed rails. Sometimes residents were in their beds and sometimes they were not when they did the bed rail assessments. During a follow-up interview on [DATE] at 10:09 AM Assessment Registered Nurse #9 stated they had been in that role since ,d+[DATE]. They did not have any specific training on completing bed rail assessments and was told they were to do the bed rail assessments and to answer the questions (on the assessment tool). Regarding making the decision as to whether a resident should have bed rails based on answering the questions on the Bed Rail Assessment tool, they stated they did not have a clear understanding of the risks involved in bed rail use. They did not realize that assist bars were considered bed rails. Not every resident received a bed rail assessment. If a resident wanted to try a bed rail they would do an assessment. When they did quarterly bed rail assessments, they would go with what the resident already had on the assessment tool, either bilateral rails or just a left or right bed rail. On admission they discussed the risks and benefits of bed rails with the resident or resident representative. Some risks of bed rails were entrapment or skin tears. They did not document the risks and benefits of bed rails because there was no place to free text on the assessment tool, and they did not write a nursing progress note. They never consulted therapy regarding bed rail assessments. They had never had an actual conversation with Resident #1's family or representative regarding their bed rail. They observed Resident #1 sleeping in their bed when the bed rail was attached, and another time observed the resident using the bed rail to get back into bed after a fall. Since they had been in their role as Assessment Registered Nurse, they had never discontinued a bed rail and they had never had a family say no to a bed rail. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 10:33 AM the Director of Nursing stated bed rail assessments were usually done by Assessment Registered Nurse #9 but sometimes they were done by Registered Nurse Unit Managers if Assessment Registered Nurse #9 was not working, or if it was off-hours. If residents had multiple risk factors during the bed rail assessment, they still might get bed rails because it would be resident-specific. They would reach out to therapy with any bed rail questions or get input from certified nurse aides about what they might think of a particular resident using bed rails. Bed rail discussions did not come up during Interdisciplinary Team meetings. There was no training plan Assessment Registered Nurse #9 received before performing bed rail assessments. Assessment Registered Nurse #9 would typically go over assessments with the Minimum Data Set Coordinator if they had any questions. When quarterly bed rail assessments were done on residents, Assessment Registered Nurse #9 should observe bed rails in person, and if there were a lot of risk factors during the assessment they should discuss these with staff on the unit. Before installation of bed rails, the risks and benefits should be discussed with the resident or resident representative and be documented. Informed consent should also be documented. Bed rails should be discussed during care plan meetings as that was a part of the topics that would be reviewed. In the past when a resident was discharged from the facility and they had bed rails, the bed rails were left on the bed. They did not consider assist rails as bed rails, but rather, as mobility devices, because the rails did not extend from the headboard to the footboard. Risks of bed rails included entrapment or injury. They observed Resident #1 using their bed rail in the past for mobility and had never heard of any issues from staff about the resident using it inappropriately. They also had never heard any concerns from therapy about Resident #1's bed rail use. During an interview on [DATE] at 11:07 AM the Medical Director stated they had not been included in resident bed rail assessments or discussions. Each residents' situation and risk factors should be reviewed in detail very carefully before bed rails were recommended. Resident #1 had been their patient and if they had been included in the bed rail assessment for them, they would have been very reluctant for the resident to have bed rails due to the risks involved, which included entrapment. In the case of Resident #1, bed rails led to their death. 10NYCRR 415.12(h)(2) ********** Immediate Jeopardy was identified, and the Administrator was notified on [DATE] at 4:44 PM. Prior to survey exit the Administrator was notified on [DATE] at 3:55 PM that Immediate Jeopardy was lifted retroactively to [DATE] based on the following corrective actions taken: -All residents with bed rails received updated bed rail assessments and physical restraint/safety assessments if their beds were placed against the wall, care plans were updated and orders for bed rails were obtained. -A revised bed rail assessment tool was created to address interventions attempted prior to bed rail installation taking into consideration medical conditions; an area on the assessment form addressed risks and benefits of bed rail use with an area for documentation; and informed consent, whether verbal or in person, by the resident or resident representative, with their name and date. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Education of staff was done for the new bed rail assessment tool, bed rail policy and procedure and safety of the residents' environment. -Plan to educate any staff that has not received training (due to illness, vacation, or leave of absence) will be completed before going on the floor to work. ********** Elopement The undated facility policy, Door Test, documented to test alarmed doors, they would go to the panel and ensure doors were alarmed, announce that the facility would conduct a test, and doors 1A, 1B, 1C, 2A, 2B, 2C, 3A, 3B and 3C were the doors that needed to be tested . They would go to the door, push the crash bar, and hold pressure against the magnet, note how long the magnet would hold the door for 15 to 20 seconds, then repeat door procedure at each of the 9 doors between the three floors in the building. They would check with the nurse to ensure the pager went off, announce the test was complete, and log into the book with the date and concerns found. The facility policy, Wandering and Elopement Risk Identification and Management, dated ,d+[DATE], documented unsafe wandering was defined as random or repetitive locomotion without regard to physical safety which placed the wandering resident or other residents at risk of harm. Comprehensive assessment of each resident for wandering behaviors and elopement risk with new onset wandering and/or elopement risk was the responsibility of the Interdisciplinary Care Planning Team. Plant Operations were responsible for ensuring the stairwell doors and exit doors were connected to the wandering management system. All staff were responsible for prompt response to all facility alerts and alarms, and immediately reporting potential issues identified with any component of the electronic wandering managements system to a licensed nurse. If alarms, systems or locking devices were temporarily disengaged or malfunctioning, ensure a backup plan was in place to safeguard the residents and consider completing a census count to ensure all residents were accounted for. 1) Resident #17 had diagnoses including Alzheimer's dementia. The [DATE] Minimum Data Set assessment documented the resident had severely impaired cognition, did not wander or reject care, had no upper or lower extremity impairments, used a walker, and used a wander/elopement alarm daily. The [DATE] comprehensive care plan documented the resident was at risk for elopement. Interventions included wander monitoring system transmitter applied to the left ankle and investigate reason for elopement attempts and document findings. The [DATE] Elopement Evaluation documented the resident had a score of 5 (a score of 1 or more was considered at risk for elopement), a history of elopement or attempted leaving the facility without informing staff, verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door, wandered, wandering behavior was a pattern, and their wandering was goal directed. The facility document Door Alarm Checks reviewed from [DATE]-[DATE] documented there were 9 doors checked with no problems. The following dates did not have documented evidence of door alarm checks: [DATE], [DATE]-[DATE], [DATE]-[DATE], [DATE], [DATE], [DATE], and [DATE]. The door checks on [DATE]-[DATE] by Maintenance Assistant #29 documented no problems. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The [DATE] at 4:25 PM Social Worker #14 progress note documented they observed the resident attempting to leave the unit via the elevator. They re-directed the resident away from the elevator. The [DATE] facility investigation documented: - At 4:22 PM the resident attempted to get on the elevator. - At 7:00 PM Registered Nurse Supervisor #19 observed the resident ambulating on the unit with their walker. - At 8:20 PM Secretary #12 received a phone call from the local gas station the resident was there. - Video surveillance of the [DATE] incident showed the resident near the end of the hall stairwell door on Unit 1 while staff members were obtaining linen and moving another resident from the shower room. Resident #17 exited the stairwell door while a staff member entered a room on the right side of the hallway. Video surveillance showed the resident exited the building with their walker at 7:37 PM, walked across the lawn and down the driveway towards the 4-lane highway in front of the facility. The resident turned left and walked down the side of the highway. Video surveillance from the front lobby at 8:24 PM showed the resident being brought back from the gas station across the street in a wheelchair, with staff carrying the resident's walker. The resident came back into the front lobby doors at 8:25 PM. - A [DATE] incident note by Registered Nurse Supervisor #32 documented Resident #17 had eloped to the gas station next door. The front lobby receptionist had received a phone call from Emergency Medical Services alerting them the resident was at the gas station. The resident was returned to the nursing home in a transport chair and placed in their bed. The resident was then moved to room [ROOM NUMBER] with all their belongings. A wander alert system was in place on their left ankle and wheelchair, and both were functioning properly. - An undated Voluntary/Witness Statement completed by Certified Nurse Aide #15 documented Resident #17 was near the door at the end of the hall on [DATE] when they went into a room to answer a call bell. They stated they did not hear any alarms and if they had, they would have responded. During an interview on [DATE] at 10:00 AM Social Worker #14 stated Resident #17 wandered because they wanted to be outside. On [DATE] the resident was attempting to get on the elevator, and they re-directed the resident. They told the certified nurse aides and Unit Manger #17. During an interview on [DATE] at 11:28 AM Assessment Registered Nurse #9 stated they completed the admission, quarterly, and annual elopement evaluations on residents. If a resident had a change in wandering or exit-seeking behavior, they would not be notified as the Unit Managers would complete the evaluations. The nurses on the units were responsible for checking placement of the wander alert devices every shift. They were told about Resident #17's elopement the next day ([DATE]) during morning report. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 10:12 AM, Maintenance Assistant #27 stated the on-call maintenance staff for the week was responsible for daily door checks. The procedure was to hold the door, monitor the alarm, and observe to see if staff responded or noticed the alarm. They were unable to identify an issue with the interior door of 1C. The outer door from 1C would normally alarm to a speaker near the nurses' station, but the speaker was blown. If the delayed egress door was held for 15 seconds and the magnet opened, it would remain open until the button on the outside of the door was pushed to reset the magnet. During a telephone interview on [DATE] at 12:43 PM Resident #17's Representative stated the resident had wandering and exit-seeking behaviors since admission. The resident would ask to go home, leave with family, and attempt to use the doors. The Administrator had reported to them about the [DATE] elopement incident. During an interview on [DATE] at 2:14 PM Maintenance Assistant #29 stated they were informed of the potential problem with 1C door on [DATE] at 6:00 AM. They had been on-call the night before but nobody had called them. They had been the on-call staff person for the week and completed the daily and weekly door checklists on [DATE]. On [DATE] they had not checked the exterior doors. The Maintenance Department checked all interior doors daily, but not the exterior doors. There was no documentation for exterior doors. During an interview on [DATE] at 2:28 PM the Director of Plant Operations #7 stated the daily checklist for doors 1A and 1C were for both doors. The checklist documented 9 doors but there were 11 doors checked. The checklist documented 9 doors without issues. However, on [DATE] it should have been documented the exterior door to 1C was not in working order. There was no daily or weekly documentation done on exterior door checks. The wander alert device checklist did not include exterior doors. During an interview on [DATE] at 5:55 PM Secretary #12 stated they received a telephone call on [DATE] that Resident #17 was at the gas station across the street. They assisted with bringing the resident back to the facility. After the resident was returned to the facility, they went to the doors the resident had exited from. The interior door (1C) opened when pushed with no alarm, and the exterior door did the same. Both doors were supposed to alarm, and the interior door was supposed to be locked with a delayed egress unless a badge was used. During an interview on [DATE] at 2:09 PM the Administrator stated the facility no longer used pagers. Instead, the nurse call board system was used. They did not know the date the facility stopped using the pagers, but it was a very long time ago. The doors in the facility were being checked on the weekly door checklist. Both doors (interior and exterior) were included with Stairwell 1C. The daily checklist was only on the interior doors. It was the responsibility of the Director of Plant Operations to ensure all the doors were checked and report back to the Administrator. They should have noticed the current door check policy was not appropriate. 2) Resident #16 had diagnoses including dementia. The [DATE] Minimum Data Set assessment documented the resident had severely impaired cognition, did not wander or reject care, used a walker, was independent with walking 150 feet, and used a wander/elopement alarm daily. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The [DATE] Elopement Evaluation documented the resident had a score of 5 (a score of 1 or more was considered at risk for elopement), a history of elopement or attempted leaving the facility without informing staff, verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door, wandered, wandering behavior was a pattern and wandering was goal-directed. The [DATE] comprehensive care plan documented the resident was at risk for elopement. Interventions included identify certain time of day wandering /elopement attempts occurred. The [DATE] at 4:35 PM Registered Nurse #35 progress note documented the resident was found on the 1 North Unit wandering at 4:20 PM. The resident stated they were looking for family who had just left the building. The resident was brought back to the 2 North Unit and was not noted to be exit seeking. A call was placed to the Director of Nursing and Unit Manager. A wander alert device was placed on the resident's left ankle. On [DATE] the comprehensive care plan was updated, and interventions included wander alert device #8 placed on left ankle. A [DATE] Elopement Evaluation completed by Assessment Nurse #9 documented the resident's elopement score was 4 (at risk for elopement). The [DATE] at 11:06 AM Registered Nurse Unit Manager #19 progress note documented they met with the interdisciplinary team, and it appeared the resident had some behaviors of packing their belongings and thought they were going to leave the building. The care plan was updated to include these behaviors and monitor them closely when exit seeking. The [DATE] at 8:25 AM Registered Nurse Unit Manager #19 progress note documented the resident's wander alert device was discontinued. Social work and secretaries were all updated. The [DATE] at 4:04 PM Registered Nurse Supervisor #17 progress note documented Receptionist #21 returned from the restroom in the lobby and looked outside the front doors and saw a resident sitting in a wheelchair with no staff or visitors in sight. They approached the resident and asked what they were doing, and the resident stated they were waiting for the bus. Receptionist #21 brought the resident back into the lobby and notified the supervisor. The [DATE] elopement investigation completed by Registered Nurse Supervisor #17 at 4:05 PM documented: -Receptionist #21 returned from the bathroom in the lobby and looked outside the front doors and saw a resident sitting in a wheelchair with no staff or visitors in sight. They approached the resident and asked what they were doing, and the resident stated they were waiting for the bus. Receptionist #21 brought the resident into lobby and notified the supervisor. -The resident had no injuries observed at the time of the incident, was ambulatory with assistance, orientated to person, they had confusion, recent changes in their medications, and impaired memory. Medical and family were notified of the event. (continued on next page)

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	335090	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Church Manor Nursing Home	863 Front Street Binghamton, NY 13905

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Receptionist #21's [DATE] at 4:05 PM written statement documented they were returning from the bathroom and looked outside and saw the resident seated in their wheelchair outside the front doors. They did not see anyone with the resident, so they went outside, and the resident stated they were waiting for the bus. They brought the resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37516 44838 Based on observation, record review, and interviews during the abbreviated survey (NY00354300), the facility failed to ensure correct installation, use, and maintenance of bed rails to ensure there was no gap between the bed rail and mattress wide enough to entrap a resident's head or body for 55 of 55 residents (Residents #1-#16 and #18-#56) reviewed. Specifically, Resident #1 had a contour mattress and a right side bed rail. The facility did not inspect and regularly check the mattress and bed rail for areas of possible entrapment. Additionally, the facility did not evaluate alternatives to bed rails, review the risks and benefits of bed rails with the resident or resident representative or obtain informed consent prior to the installation of bed rails for Resident #1 and all 54 residents with bed rails (Refer to F689). Subsequently, on [DATE], Resident #1was found with their body out of their bed with their head wedged between the bed rail and the mattress. The resident had no pulse or respirations and was pronounced deceased . This resulted in Immediate Jeopardy for Resident #1 and placed the remaining 54 residents with bed rails at risk for the likelihood for serious injury, serious impairment, serious harm, or death. Findings include: The facility policy, Side Rail Use, revised/reviewed [DATE], documented the facility would ensure correct installation, use, and maintenance of bed rails for resident safety when rail use was necessary to treat a resident's medical symptoms or assist with mobility and/or transfer. Entrapment was an event in which a resident was caught, trapped, or entangled in the spaces in or about the side rail, mattress, or hospital bed frame. Seven zones for potential bed entrapment were identified including Zone 3, between the side rail and the mattress. Risks to the resident related to rail use included but were not limited to: accident hazards/barrier to residents from safely getting out of bed; a resident could crawl over rails and fall from greater heights increasing the risk for serious injury, and entrapment.; when installing and using side rails, following the manufacturer recommendations/specifications and inspect regularly and checking the mattress and side rails for areas of possible entrapment, ensuring there was no gap wide enough to entrap a resident's head or body. References used included U.S. Food & Drug Administration (FDA) Bed Rail Safety, Recommendations for Health Care Providers about Bed Rails, Updated: [DATE]. Hospital Bed Safety Workgroup, and Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings. [DATE]. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The U.S. Food & Drug Administration (FDA) Bed Rail Safety, Recommendations for Health Care Providers about Bed Rails, updated: [DATE], documented to follow the recommendations in their guidance Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated [DATE]. Dimensional limits for entrapment Zones,d+[DATE] to reduce the risk for entrapment. Zone 3 was the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment when taking into account the mattress compressibility, any lateral shift of the mattress or rail, and degree of play from loosened rails. The recommendations were for a dimension of less than 4 ,d+[DATE] inches because the head is presumed to enter the space before the neck. The undated facility policy, Safe Environment, documented the facility would ensure regular inspection, testing (if applicable), and maintenance of emergency safety equipment, facility systems, and equipment would be completed in accordance with manufacturer's recommendations/specifications and all pertinent Federal, State, and municipality requirements. Examples included, but were not limited to, beds and bed rails. On [DATE], the facility provided a list of 54 residents in the facility who currently had bed rails on their beds. Resident #1 had diagnoses including Alzheimer's disease. The [DATE] Minimum Data Set Assessment documented the resident had severely impaired cognition, required partial to moderate assistance for rolling left to right and sitting on the side of the bed, supervision or touching assistance to stand and for chair/bed to chair transfer, and did not use bed rails. A [DATE] at 7:49 AM Registered Nurse #3 progress note documented they were called to the resident's room at approximately 5:45 AM. The resident was found beside the bed in a kneeling position, with their head caught between the bed rail and the mattress. The resident was moved back to the bed for assessment and was found to be without respirations or audible heart tones. A [DATE] facility incident report documented the resident was last observed at approximately 4:30 AM for incontinence care. At 5:45 AM, when Licensed Practical Nurse #4 entered the resident's room to administer medication, the resident was observed with their head and neck between the right side bed rail and mattress. After assessment by Registered Nurse #3, the resident was pronounced deceased . The Certificate of Death documented the resident expired at approximately 5:45 AM on [DATE] with immediate cause of death listed as probable positional asphyxiation. The certificate was signed by the coroner. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 9:33 AM, Facilities Supervisor #6 stated maintenance put mattresses and bed rails on beds. Work orders were placed by nursing for mattresses or bed rails. The different types of mattresses were regular, raised side mattresses, and some air mattresses. All facility staff were able to access work orders and prioritize according to importance. There were two bed sizes in the facility: regular width and bariatric. Bariatric beds were wider than regular beds. Mattresses were specific to bed size; proper sized mattresses were important to make sure residents did not fall out of bed. Bed safety checks were done annually and were inspected for all wheels, brakes, assist bars, headboard, and bed control operation. A visual inspection was done every other month. Bed rails used at the facility were referred to as assist rails and they were smaller and narrower than a regular bed rail. They were meant to be used for a resident to get in and out of bed. Bed rails should have a work order and should not be placed or removed without a work order from nursing or therapy. Maintenance checked brakes to make sure they were engaged, and the bed did not move, the bed controller for proper functioning, and the mattress for its current condition. Staff should be looking at mattresses when changing linen and when cleaning. They did not have a bed measuring tool or process for measuring entrapment risk zones. They had heard about guidelines for bed safety but did not have specific measurements to check for. The facility only had one brand of bed, and the assist rails were manufacturer specific to those beds. Their checklist did not include entrapment guidelines. Any gaps for residents to become entrapped put residents at risk for injury or worse. During an interview on [DATE] at 10:30 AM, Facilities Director #7 stated they oversaw maintenance for the whole campus for about the last year-and-a-half. They were not very familiar with guidelines for prevention of bed entrapment. Facility staff did the inspections, mattress changes were done by maintenance, and they were not sure if they inspected via the checklist at the time of any change. The facility used manufacturer specific mattresses and bed rails to try to ensure resident safety. Some bed rails had been removed following the incident on [DATE]. During observations on [DATE] between 1:00 PM and 3:00 PM, bed entrapment zones were measured as identified by the U.S. Food and Drug Administration's Hospital Bed Safety Workgroup Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings using a bed system measurement tool. A total of 7 beds were sampled (Residents #1, #4, #5, #6, #7, #8 and #9). All 7 beds were out of compliance with Zone 3 entrapment guidelines (the space between the mattress and the side rail should be no greater than 4 and ,d+[DATE] inches). One of the 7 measured beds belonged to Resident #1. On [DATE] the facility provided their bed preventative maintenance inspection chart completed annually by maintenance. It included parts of a bed that were found worn or defective and should be replaced. There was no documented evidence the facility measured beds for entrapment risk. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 1:18 PM, the Administrator stated bed rail use was determined by an assessment, generally at the request of resident or family member. The Interdisciplinary Team then determined need, an assessment was completed by nursing using an assessment tool, and then discussion to make sure bed rails were appropriate and safe based on assessment criteria. It would be expected that an observation of the resident using bed rails would take place during the assessment. Maintenance installed bed rails at the request of nursing. They should be checking that the bed rail fit appropriately and was consistent with manufacturer's guidelines and U.S. Food and Drug Administration entrapment zones. Maintenance performed bed safety checks, making sure beds were safe and in good working order. They were not performing specific measurements regarding U.S. Food and Drug Administration entrapment guidelines. Risks associated with bed rail use included serious bodily injury and death. There had been no specific training in the past year regarding bed rail use. 10NYCRR 415.12(h)(1)(2) ********** Immediate Jeopardy was identified, and the Administrator was notified on [DATE] at 4:39 PM. Prior to survey exit the Administrator was notified on [DATE] at 3:55 PM that Immediate Jeopardy was lifted retroactively to [DATE] based on the following corrective actions taken: -Maintenance was trained on entrapment zones and how to measure per FDA guidelines. 100% completed on [DATE]. -An audit tool that contained all aspects of bed safety, compatibility of bed, mattress, and bed rails; mattress inspection, and entrapment zones was completed for all beds in the facility on [DATE]. -The updated bed rail policy and procedure was provided which included Maintenance will check the bed model and install a compatible bed rail. Once installed the bed will be checked prior to use for entrapment zones, and if any are determined to be non-compliant the device will be un-installed immediately and nursing will be informed. Maintenance will close out the work order ticket once completed and update nursing of completion. Staff education as of [DATE] was 98%. -A bed rail process and procedure audit tool was developed to monitor alternatives tried, bed rail assessment completed, Interdisciplinary Team review, care plan update, consent after provision of information, order in place, maintenance measured, monitoring resident safety, and physical restraint assessment. -Continued education provided to all direct care workers, housekeeping, maintenance, social work, therapy, and activities are reminded of bed safety, entrapment zones, bed placement and potential for creating entrapment zones. Mattresses should not move on the bed frame. Mattress stops located on the 4 corners of the bed frame. Staff are responsible for reporting any entrapment zone issues or concerns. All staff who are actively employed by the facility have been trained. -Education of staff that has not received training (due to illness, vacation, or leave of absence) will be completed before reporting to their workstations on their next schedule day.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 Based on observation, record review, and interviews during abbreviated surveys (NY00354147 and NY00354300), it was determined the facility and governing body failed to ensure that residents received appropriate quality of care by allowing the following deficient practices to exist, placing residents at risk for serious injury, serious harm, serious impairment, or death: F 689 Accident Hazards and F 700 Bedrails. Specifically, the facility's governing body did not establish and implement policies regarding the management and operation of the facility. Subsequently, there were outdated and a lack of operational policies and equipment to ensure resident safety. Findings include: The facility policy Quality Assurance Performance Improvement, dated ,d+[DATE] defined governing body as individuals who were legally responsible for establishing and implementing policies regarding the management and operations of the facility. A quality deficiency was anything the facility considered to be in need of further investigation and correction or improvement. Examples included problems such as accidents. It was the responsibility of the Governing Body to maintain accountability and responsibility for the facility (Quality Assurance Performance Improvement) program, ensuring the ongoing Quality Assurance Performance Improvement program was defined, maintained, and addressed identified priorities. The Governing Body was also responsible for holding the facility responsible and accountable for collaborating with the governing body and ensuring that the ongoing Quality Assurance Performance Improvement program was sustained during transitions in leadership and staffing. Refer to Free of Accident Hazards/Supervision/Devices (F 689), Elopement: - Resident #17 did not have behaviors consistently monitored and documented prior to elopement on [DATE]. Subsequently, Resident #17 exited the building at 7:37 PM, crossed a 4 lane road to a gas station, and was returned to the facility at approximately 8:25 PM. - The facility policy/procedure and checklist for door tests were not updated timely. Subsequently, the exterior doors of the facility were not consistently monitored, and their working condition was not documented. - This resulted in Immediate Jeopardy for Resident #17 and all residents at risk for elopement with wandering behaviors. Refer to Free of Accident Hazards/Supervision/Devices (F 689), Bedrail Assessments: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Resident #1 had a contour mattress, a right bedrail, and the left side of the bed was against the wall. The facility failed to assess the resident for appropriate alternatives to bedrails or review the risks and benefits of bedrails with the resident representative and obtain informed consent with the resident representative. Subsequently, on [DATE], the resident was found with their body out of the bed, their head wedged between the bedrail and the mattress, and they were pronounced deceased . This resulted in Immediate Jeopardy for Resident #1 and all 54 residents with bedrails. Refer to Bedrails (F 700), Bedrail Maintenance: - Resident #1 had a contour mattress, a right bedrail, and the left side of the bed against the wall. The facility did not inspect and regularly check mattresses and bedrails for areas of possible entrapment per Food and Drug Administration guidelines. Subsequently, on [DATE], Resident #1 was found with their body out of the bed and their head wedged between the bedrail and the mattress. The resident had no pulse or respirations and was pronounced deceased . This resulted in Immediate Jeopardy for Resident #1 and all 54 residents with bedrails. During an interview on [DATE] at 2:09 PM, the Administrator stated they were the Chief Operations Officer for the organization and became the Acting Administrator on [DATE]. As Chief Operations Officer they monitored the facility operations as part of the corporate team. The facility reported monthly operational reviews that included clinical, financial, and overview of everything from nursing to dietary and admissions. The former Administrator reported up to the Chief Operations Officer on everything including plant operations. The senior leadership of the organization and clinical operations team were responsible for updating policies and procedures. The Administrator should have been overseeing the maintenance department and identifying the lack of bedrail measurements. They should have also noticed the door check policy was not appropriate given the equipment in the policy was no longer in the building. They stated they implemented a new door check policy on [DATE]. 10NYCRR 415.26(b)(3)(1)