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	08/22/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 44838 Based on observation, record review, and interview during the recertification survey conducted 8/19/2024-8/22/2024, the facility did not ensure a resident's ability to safely self-administer medications was clinically appropriate for 1 of 1 resident (Resident #74) reviewed. Specifically, Resident #74 was observed with medications stored in an unlocked drawer of their dresser, and there was no documented evidence the interdisciplinary team had assessed the resident's ability to safely self-administer medication. Findings include: The facility policy, Medication Self-Administration, dated 5/2005 documented a resident who wished to self-administer medications, was to be determined to be capable of safely doing so by the interdisciplinary team, arrange for storage of medications in locked drawer or box in the resident's room, and observe self-administration until compliance was assured. Resident #74 had diagnoses of acute pancreatitis (inflammation of the pancreas), myasthenia gravis (a disease causing weakness in voluntary muscles), and diabetes. The 8/2/2024 Minimum Data Set assessment (a health assessment tool) documented the resident had intact cognition, required minimal assistance with activities of daily living, and received insulin 7 of 7 days. Physician's orders documented: -On 4/27/2024 Creon (enzymes to aid in digestion) delayed release particles 36000-114000 unit 1 capsule by mouth before meals for digestive support, unsupervised self-administration. The resident was to keep medication in blister pack in locked drawer and was able to self-administer medication. -On 4/27/2024 pyridostigmine bromide (used to treat myasthenia gravis) oral tablet 60 milligrams, give 1 tablet by mouth before meals for myasthenia gravis, unsupervised self-administration. The resident was to keep medication in blister pack in locked drawer and was able to self-administer medication. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The August 2024 Medication Administration Record documented Creon delayed release particles 36000-114000 unit 1 capsule by mouth before meals for digestive support, unsupervised self-administration. Resident keeps medication in blister pack in locked drawer and was able to self-administer medication. Pyridostigmine bromide oral tablet 60 milligrams give 1 tablet by mouth before meals for myasthenia gravis, unsupervised self-administration. Resident keeps medication in blister pack in locked drawer and was able to self-administer medication. Both medications were documented as self-administered unsupervised daily at 7:00 AM, 11:30 AM and 4:30 PM from 8/1/2024-8/19/2024. The Comprehensive Care Plan did not include self-administration of medications and interventions. There was no documented evidence of a resident assessment for medication self-administration. During an observation on 8/19/2024 at 12:25 PM, Resident #74 had a small medicine cup containing a white pill, and a capsule with a blue end. They stated they would self-administer these medications. During a medication administration observation and interview on 8/20/2024 at 12:06 PM, Licensed Practical Nurse #1 provided the glucose meter and resident's insulin pen to the resident. They stated the resident was being provided oversight and teaching for self-administration of insulin. They stated the resident also self-administered their Creon and pyridostigmine. They signed in the medication administration record that those medications were taken but did not have to count the pills or directly observe the resident taking them. They were not sure where the resident kept the pills, but they should be kept in a locked space. During a lunch observation and interview on 8/20/2024 at 12:26 PM, the resident had pills in a medication cup at the dining room table. They stated the medications were Creon and pyridostigmine bromide. They kept them in their top dresser drawer which did not lock. They stated they did not have a key for any drawers. The nurse did not check on the medication, but they let the nurse know when they needed more ordered. They received permission to self-administer medications. They stated other residents did not wander into their room. During an interview on 8/20/2024 at 1:12 PM, Registered Nurse Unit Manager #2 stated residents were assessed for safe self-administration of medications. Resident #74 did self-administer Creon and pyridostigmine, and they were not sure if an assessment had been completed. The medications were supposed to be kept in a locked drawer, so they were not accessible to other residents. They observed the resident's unlocked top dresser drawer which contained 2 full blister packs and one partial blister pack of the pyridostigmine (81 total pills), and 1 full blister pack and 1 partial blister pack of the Creon (57 total pills). Registered Nurse Unit Manager #2 stated the medications were not counted by nursing, and the resident should have been provided one blister pack at a time. When pharmacy delivered the medication, all the blister packs must have been given to the resident. During an interview on 8/22/2024 at 10:49 AM, the Assistant Director of Nursing stated that residents should have an assessment for safe self-medication administration, and a care plan that documented a resident specific plan. Medications should be kept locked so they could only be accessed by the resident and should be checked by nursing to ensure compliance. 10NYCRR 415.3(e)(1)(vi)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44838 Based on observation, interview, and record review during the recertification survey conducted 8/19/2024-8/22/2024, the facility did not ensure the right to reside and receive services with reasonable accommodation of resident needs and preferences for 1 of 1 resident (Resident #71) reviewed. Specifically, Resident #71's call bell was not in reach as care planned. Findings included: The facility policy, Call System, dated 1/7/2016 documented residents in their rooms, toilet, and bathing areas should have a means of directly contacting caregivers and should be responded to in a timely manner. Upon admission, attempt to orient the resident to the purpose for and use of the call system. Ensure that the resident could use the call system device, making adaptations for limited hand dexterity or other physical limitations to the extent reasonable. Ensure the call system device was in reach of the resident if the resident was capable of using it. Resident # 71 had diagnoses including Alzheimer's disease and dysphagia (difficulty swallowing). The 7/14/2024 Minimum Data Set assessment (a health status assessment tool) documented the resident was usually able to make themself understood and understood others, had severely impaired cognition, was independent with bed mobility, transfers, and ambulation, and required moderate to maximal assistance with personal hygiene and dressing. The Comprehensive Care Plan initiated 8/1/2023 documented the resident was at high risk for falls related to gait/balance problems. Interventions included anticipate and meet resident's needs, and to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance. The following observations were made: - on 8/19/2024 at 9:54 AM, the resident was in bed, their call bell was hooked to itself at the wall out of the resident's reach. - on 8/20/2024 at 9:09 AM, the resident was in bed, their call bell was under a chair out of the resident's reach. - on 8/20/2024 at 1:10 PM, the resident was in bed, their call bell was on the floor under a chair out of the resident's reach. During an interview on 8/20/2024 at 1:55 PM, Certified Nurse Aide #18 stated residents should have their call bells in reach. They stated the call bell was currently under the chair at the resident's bedside and was not in the resident's reach. Certified Nurse Aide #18 thought the resident could use the call bell and it was important to keep the call bell in reach so the resident could communicate if they needed something. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/2024 at 2:34 PM, Registered Nurse Unit Manager #2 stated call bells should always be in resident's reach. It was important so a resident could call for assistance or if they needed something. They stated it should be care planned if a resident needed an alternative call device or was unable to use a call bell. They thought Resident #71 could use the call bell but was not sure if they would. During an interview on 8/22/2024 at 10:18 AM, Licensed Practical Nurse #1 stated resident call bells should be in reach, so residents were able to communicate needs. Keeping them in reach could help prevent falls or accidents. If a resident was unable to use a call bell, an alternative should be provided, and their care plan should be updated. Resident # 71 may not cognitively be able to use the call bell. If they could not use a call bell, it should have been in the care plan. During an interview on 8/22/2024 at 10:49 AM, the Assistant Director of Nursing stated resident call bells were used to communicate a resident need or an emergency. If a care plan stated to keep the call bell in reach, it should be kept in reach. If a resident was unable to use a call bell, other alternatives should have been put in place. They were not sure if Resident #71 was able to use their call bell. 10NYCRR 415.5(e)(1)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 Based on record review and interviews during the recertification survey conducted 8/19/2024-8/22/2024, the facility did not make prompt efforts to resolve resident grievances for 3 of 8 anonymous residents and for 5 additional grievances (Residents #38 [2 grievances], #47, #79, and #94) reviewed. Specifically, 3 residents from the Resident Council meeting stated their grievances were not always acted upon or resolved and they were not provided with a reason why. Additionally, there were five grievances that did not have documented resolution. Findings include: The facility policy Grievances, reviewed 8/2017, documented the facility would ensure prompt resolution of all grievances regarding the resident's rights. The Grievance Official was responsible for overseeing the grievance process through to its' conclusion and issuing written grievance decisions to the resident. Prompt efforts to resolve included the facility acknowledgement of the grievance and active work toward the resolution of the grievance. A written grievance decision was a document that included the intake, investigation and resolution process for each grievance received. When a group presented grievances or recommendations concerning policy or operational decisions affecting resident care and life in the facility, the facility must consider the views of the resident and/or group and be able to demonstrate facility response, rational for such response, and communicate the response to the resident and/or group. The facility policy. Resident Rights, reviewed 2/1/2024, documented residents had the right to voice grievances and have the facility respond to those grievances. During a Resident Council meeting on 08/20/2024 at 10:59 AM, three anonymous residents stated the facility does not always act upon grievances or recommendations. They were not always told why the facility did not follow through on a grievance or concern. One anonymous resident stated they had asked for gluten-free pasta, and they had not received a response. Three anonymous residents stated they brought up the garden in the courtyard was overgrown with weeds that blocked the view from some of the resident windows and made sitting out in the courtyard unenjoyable. The facility had not taken care of it, and the courtyard was still overgrown. The Resident Council meeting notes dated 8/12/2024, documented a resident had asked that the garbage cans be removed from under the American flag in the dining room. The facility response on the resident council minutes documented the garbage cans would be removed and signs would be put up not to place things in that area. During an observation on 8/21/2024 at 10:36 AM, the American flag in the first floor dining room had a trash can directly to the right of the flag with the bottom of the flag just about touching the top of the trash can. There were signs that documented Do not place items under the flag to the left of the flag and behind it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/21/2024 at 10:38 AM, the courtyard garden along the right-side windows of the building on the first floor was overgrown with weeds, plants, and grass. The overgrowth blocked the views of 4 windows in resident rooms [ROOM NUMBERS]. Grievances from 8/2023 to 8/2024 documented the following: - An undated grievance form for Resident #94 documented the resident was missing a wheelchair that was personally bought and brought in by the resident's family. The form documented the facility had searched for the wheelchair and had not found it. There was a note on the grievance documenting if the family wished for the wheelchair to be replaced, a receipt needed to be brought in for replacement. There was no documented resolution or notification provided to the resident or family. - A grievance form dated 10/6/2023 for Resident #38 documented the resident was missing a left hearing aide. A search was completed by the facility, the hearing aid was not located, and a voicemail was left for the resident's responsible party. There was no documented resolution to the grievance or a date the grievance had been resolved. - A printed email from Resident #47's family member dated 12/4/2023 documented Resident #47 was missing dentures and a personal television remote control. There was no grievance form completed. The email had handwritten documentation Complete review and investigation completed. Unable to locate the dentures or emote. Email notification sent on 12/12. There was no documented resolution to the grievance. - A grievance form dated 12/10/2023 for Resident #79 documented the resident had received a curdled glass of milk with dinner. The action documented the Food Services Director was to call the resident's family regarding the issue. There was no documentation the Food Service called the family or of a resolution. - A grievance form dated 1/22/2024 for Resident #38 documented the resident's left hearing aid was stepped on and broken by a nurse. A call was placed to the resident's family and the facility would replace the hearing aid when the hearing aid company was located. There was no follow up or resolution documented on the grievance form or a date the grievance was resolved. During an interview on 8/22/2024 at 8:48 AM, the Social Services Director stated the process for grievances was the residents came to them with a grievance, and they documented it. They notified the appropriate staff and the resident or family member of the follow up or resolution if there was one. They do not know what the exact time frame to resolve a grievance was, but they tried to resolve grievances as soon as possible. If a resident had a missing item that was unable to be located, the facility usually replaced it. The facility had only started using paper forms as of 8/2023 when they switched to their new electronic medical record system. Previously, the grievances had been logged and completed in their old electronic medical record. Each grievance should have documented follow up and resolution. The Social Services Director reviewed the five grievances from binder without resolutions and stated they would not know by looking at the forms the grievances were resolved. Each one should have documented follow up and the date it was resolved. They were aware that residents had an issue with the courtyard garden being overgrown. They were unaware if anyone had followed up with the residents regarding a resolution to the overgrowth in the courtyard. They stated residents informed them they did not feel the concerns they brought up were being addressed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/2024 at 10:44 AM, the Administrator stated the Social Services Director was the Grievance Officer. The facility asked the resident's to put grievances in writing and the Grievance Officer would follow up with the appropriate people for resolution. If the grievance was unable to be resolved, it came back to them to try to settle on a resolution. The resolution to the grievance should be documented on the grievance form because staff change and if anyone inquired about the status of the grievance, it would be documented if it was resolved or not resolved. They were aware of all five grievances that did not have a resolution documented and they should have as they were unable to tell if they were resolved. They were aware the residents were unhappy with the overgrown garden in the courtyard. They used to have a volunteer that weeded the garden but no longer did. It was also maintained by the activities department in the past, but it had been a crazy summer and had not been maintained. They were unaware residents felt their concerns and grievances were not being resolved. 10NYCRR 415.3(C)(1)(ii)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44838 48052 48675 Based on observation, record review, and interview during the recertification survey conducted 8/19/2024-8/22/2024, the facility did not develop and implement a comprehensive person-centered care plan to meet the resident's medical and nursing needs for 4 of 8 residents (Resident #3, #58, #74, and #93) reviewed. Specifically, Resident #93's comprehensive care plan did not include pain management and hospice services; Resident #47's comprehensive care plan did not include the use of antipsychotic medications; Resident #74's comprehensive care plan did not include self-medication administration or diabetes; and Resident #3's comprehensive care plan did not include ordered interventions for edema (swelling). Findings include: The undated facility policy, Resident-Centered Standards of Care and Exceptional Care Planning, documented the facility utilized standards of care and developed exceptional resident-centered care plans that were culturally competent and consistent with the resident's specific conditions, risks, needs, history, behaviors, preferences, and with current standards of practice to meet the resident's medical, nursing, mental, and psychosocial needs. The interdisciplinary team would periodically reassess the resident and review/update the resident's plan of care: when there was a change in condition, when the desired outcome was not met, when the resident was readmitted after a hospital stay, when the care plan was no longer consistent with the resident's wishes and treatment goals, when revisions were requested by the resident, and at a minimum after each comprehensive and quarterly review assessment. 1) Resident #93 had diagnoses including palliative care, bladder mass, and pain in the right and left hip. The 6/27/2024 Minimum Data Set assessment (resident assessment tool) documented the resident had severely impaired cognition, required partial/moderate assistance with most activities of daily living, was frequently in pain, received routine and as needed pain medication, and received hospice care (program that focuses on quality of life and comfort near the end of life). The 3/22/2024 physician order documented morphine sulfate (an opioid pain medication that treats moderate to severe pain) oral solution 0.25 milliliters every 2 hours as needed for severe pain and refer the resident to hospice services. The resident was admitted to hospice services on 3/25/2024 through a local hospital contract. The hospice plan of care included pain interventions and symptom management. Interventions included notify physician if reported pain was above the resident's tolerable level of 4 out of 10 (pain scale 1-10) and unrelieved by current treatment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/24/2024 hospice progress note documented the hospice Social Worker and Registered Nurse Case Manager had a joint visit to see the resident due to two falls and increased frequency of morphine use. The resident complained of vaginal pain. Nursing progress notes dated 5/1/2024-8/17/2024 did not document collaboration or communication with hospice regarding the resident's condition. The 8/15/2024 Family Nurse Practitioner #22 progress note documented the resident was seen for increased pain, was given an extra dose of morphine for breakthrough pain, and they would increase the morphine to 10 milligrams four times a day and 10 milligrams every hour as needed. There was no documented evidence the Comprehensive Care Plan included a coordinated plan of care with the hospice provider to ensure the needs of the resident were addressed, including pain management. During an interview on 8/21/2024 at 2:26 PM, Certified Nurse Aide #10 stated they looked at the resident's care plan or care instructions (Kardex) to know how to properly care for them. They stated Resident #93's care instructions did not include their hospice plan or pain management. If staff was not familiar with Resident #93, they would not know what to monitor for. During an interview on 8/21/2024 at 2:38 PM, Licensed Practical Nurse #15 stated they were unsure of the care planning process, they did not initiate or update care plans, and the registered nurses were responsible for resident's care plans. They stated care plans were started upon admission and they were unsure how often they were reviewed. Care plans were resident specific, and it was important to keep them updated so staff would know how to properly care for the resident. If they were not accurate there was a risk the resident would not receive the care they needed. They stated Resident #93 was on hospice, in lots of pain, and was receiving pain medications frequently. Resident #93's care plan should have included their pain, pain medications, and hospice services so the staff would know what was going on with the resident and how to care for them. 2) Resident #47 had diagnoses including severe dementia with agitation, anxiety, and insomnia. The 6/21/2024 Minimum Data Set (a health assessment tool) documented the resident was rarely or never understood, had severely impaired cognitive skills for daily decision making, had no behavioral symptoms, was dependent for care, received an antipsychotic daily, and a gradual dose reduction was clinically contraindicated. The 9/19/2023 comprehensive Minimum Data Set assessment documented psychotropic drug use was triggered and care planned. A 1/9/2024 physician order documented risperidone (antipsychotic) 0.5 milligrams 1 tablet two times daily for dementing illnesses with associated behaviors. The 9/1/2023 Comprehensive Care Plan documented the resident had impaired cognitive function related to dementia without behavioral disturbance. The interventions included ask yes/no questions to determine the resident's needs, refer to the activities care plan, use task segmentation to support short-term memory, and reminisce with the resident using photos of family and friends. There was no documented evidence the resident had a care plan for use of an antipsychotic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/2024 at 9:40 AM, the Registered Nurse Unit Manager #6 stated the care plans were an interdisciplinary team approach, but they did the care plans for the nursing problems and most medications. Antipsychotics should be included in the care plan. Both social work and nursing were responsible for the antipsychotic medication care plans. As the Unit Manager they would try to make sure it was in the care plan. Registered Nurse Unit Manager #5 stated the resident did not have a care plan for their antipsychotic medication and they should. It was important to have the medication care planned for so the resident could be monitored for any adverse reactions, like tardive dyskinesia (involuntary movements, a possible side effect of antipsychotics), how the resident tolerated the medication, and for gradual dose reduction. 3) Resident #74 had diagnoses of acute pancreatitis (inflammation of the pancreas), myasthenia gravis (a disease causing weakness in voluntary muscles), and diabetes. The 8/2/2024 Minimum Data Set assessment (a health assessment tool) documented the resident had intact cognition, required minimal assistance with activities of daily living, and received insulin every day. Physician's orders documented: - on 4/27/2024 Creon delayed release particles 36000-114000 unit (enzymes to aid in digestion) 1 capsule by mouth before meals for digestive support, unsupervised self-administration. Resident kept medication in blister pack in locked drawer and was able to self-administer medication. Pyridostigmine bromide oral tablet 60 milligrams (a medication used to treat myasthenia gravis) give 1 tablet by mouth before meals for myasthenia gravis, unsupervised self-administration. Resident keeps medication in blister pack in locked drawer and was able to self-administer medication. -6/21/2024 Novolog (insulin aspart) inject per sliding scale before meals and at bedtime for diabetes mellitus. There was no documented evidence the Comprehensive Care Plan included the diagnosis of diabetes or the resident's ability to self-administer medication with associated goals and interventions. During an interview on 8/22/2024 at 9:45 AM, Registered Nurse Unit Manager #2 stated staff looked at resident care plans and care instructions (Kardex) to know how to properly provide care. Care plans were resident specific and communicated the resident's safety needs, preferences, diagnoses, risks, and medications that needed monitoring. The care plan information generated onto the care instructions, so staff were aware of the resident needs or changes in their care. Registered Nurse Unit Managers and other disciplines were responsible for developing and updating care plans. Resident #93 should have had a pain care plan in place and a hospice care plan should have been initiated when Resident #93 was started on Hospice services. Resident #74 should have a care plan in place for diabetes mellitus, and self-administration of medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/2024 at 10:49 AM, the Assistant Director of Nursing stated care plans were used to provide proper care based on each resident's preferences, safety needs, diagnoses, and medications. Diabetes, pain, anticoagulants, antipsychotics, should all have a care plan to identify risks and monitor effects of interventions. Resident #93 should have a pain care plan so staff was aware, and it would have included non-pharmacologic (methods that did not include medications) interventions that could have been effective. Resident #93 should also have a hospice care plan initiated when they started services that included interventions to maintain their comfort and quality of life. Resident #74 should have a care plan for diabetes to monitor for signs of hyper/hypoglycemia (high and low blood sugar level). There should also be a self-medication administration care plan for Resident #74 addressing safe storage of medications, and monitoring of compliance by nursing. 10NYCRR 415.11(c)(1)

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Elizabeth Church Manor Nursing Home	863 Front Street Binghamton, NY 13905

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44838 Based on observation, record review, and interview during the recertification and abbreviated (NY00322036) surveys conducted 8/19/2024-8/22/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 2 of 3 residents (Residents #6 and #71) reviewed. Specifically, Residents #6 and #71 were not assisted with toileting as planned. Findings include: The facility policy, Activities of Daily Living- Functional Impairment, dated 5/2019 documented residents would maintain dignity and self-esteem related to activities of daily living self-performance. Nursing provided the resident activity of daily living support at the level required, as specified in the electronic health record plan of care. 1) Resident #6 had diagnoses including dementia and history of urinary tract infections. The 6/12/2024 Minimum Data Set assessment (a health assessment tool) documented the resident had severe cognitive impairment, did not reject care, was dependent on staff for transfers, bed mobility and toileting, and was always incontinent of bladder and bowel. The comprehensive care plan initiated 8/15/2023 documented the resident had bladder and bowel incontinence related to dementia. Interventions included to check and change the resident every 2 hours, monitor for signs of a urinary tract infection, monitor skin for redness, breakdown, or irritation, and offer the bedpan every 4 hours (per urology recommendations). The resident had an activity of daily living self-care performance deficit related to limited mobility. Interventions included to check and change every 2 hours, and the resident required total staff assistance for bed mobility and toileting care. The resident care information (Kardex) documented to check the resident every 2 hours and assist with toileting care as needed and to provide total assistance with toileting care. The resident care task form for August 2024 documented on 8/20/2024 the resident was checked and changed at 4:18 AM, 9:41 AM, and 4:00 PM. During a continuous observation on 8/20/2024 at 9:33 AM Resident #6 was assisted in their wheelchair to the common area. The resident remained in the common area until 12:15 PM when they were assisted to the dining room for lunch. At 1:55 PM the resident was assisted to their room for care. Certified Nurse Aides # 18 and 19 entered the resident's room to provide care. The resident was transferred to their bed using a mechanical lift. The resident's brief was wet. The resident stated they were unsure how long their brief had been wet. The resident was not checked or provided incontinence care from 9:33 AM to 1:55 PM (approximately 4 1/2 hours). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/2024 at 2:10 PM, Certified Nurse Aide #19 stated Resident #6 was not on their assignment today. They were asked to assist with care after lunch, and that was the first care they had given the resident that shift. Residents should be checked and changed every 2-4 hours depending on the resident. Being in a wet brief was uncomfortable for the resident, and not good for their skin. During an interview on 8/20/2024 at 2:15 PM, Certified Nurse Side #18 stated they provided morning care for Resident #6 and brought them to the family room about 9:30 AM. They had not provided any care to the resident since the morning care. The resident was supposed to be checked and changed (if needed) every 2 hours. It was important to check and change frequently due to risk for urinary tract infections or skin breakdown. They were not sure why they had not checked the resident prior to lunch. 2) Resident # 71 had diagnoses of Alzheimer's disease and Crohn's disease (chronic inflammation of the bowel that can cause diarrhea). The 7/14/2024 Minimum Data Set assessment documented the resident was usually able to make self understood and to understand others, had severely impaired cognition, rejected care 1 to 3 days, was dependent on staff for toileting hygiene, required moderate to maximal assistance with personal hygiene and dressing, was at risk for developing pressure ulcers, and was always incontinent of bladder and bowel. The comprehensive care plan initiated 8/1/2023 documented the resident had an activity of daily living self-care performance deficit. Interventions included total assistance of one for toileting care and encourage the resident to use the call bell for assistance. The comprehensive care plan initiated 8/6/2023 documented the resident had urinary and bowel incontinence. Interventions included check and change the resident every 2 hours. During a continuous observation on 8/20/2024 at 9:09 AM the resident was in a low bed with a hospital gown on and their call bell was under a chair at their bedside. At 1:10 PM they remained in bed in a hospital gown with lunch on the overbed table with the drinks covered, and their call bell on floor under chair at bedside. At 1:38 PM they remained in bed, with no call bell in reach. They were awake with no staff interaction observed during the meal and a urine odor was noticeable in the room. The resident was not toileted from 9:09 AM-1:38 PM. The resident care task form for August 2024 documented on 8/20/2024 the resident was checked and changed at 4:12 AM, 9:38 AM, and 2:39 PM. During an interview on 8/20/2024 at 2:15 PM, Certified Nurse Aide #18 stated Resident #71 was supposed to be checked and changed every 2 hours. The resident was resistive, very combative, refused to get out of bed, and refused care. They stated they did not report the refusal of care to anyone and was not sure if they were supposed to report refusals to the nurse. They did not ask anybody else to approach the resident to try to provide care or get up assistance. The resident had received no care on the day shift. The lack of care could increase the risk for skin breakdown and urinary tract infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/2024 at 2:27 PM, Certified Nurse Aide #20 stated Residents # 6 and #71 were not on their assignment today and they had not provided care to either resident. If a resident was combative, they should be reapproached or ask another aide to approach. They had not been asked to assist with any resistive residents today. Residents not receiving timely care were at risk for skin breakdown and further discomfort. Care refusals should be reported to the nurse. During an interview on 8/20/2024 at 2:34 PM, Registered Nurse Unit Manager #2 stated residents should be checked for incontinence every 2 hours and changed if needed. If they were left without care they were at risk for increased urinary tract infections and skin breakdown. Poor hygiene could negatively affect the resident's dignity. Residents' refusal of care should be reported to the nurse. Staff should reapproach and sometimes another aide could try. They had not been notified of Resident #71's refusal of care. During an interview on 8/22/2024 at 10:18 AM, Licensed Practical Nurse #1 stated every refusal of attempted care should be communicated to the nurse so the nurse could attempt and document. All residents should be checked or offered toileting every 2 hours. If care was refused, it must be attempted again, and a different staff member should try. Checking and changing the resident should be done at least every 2 hours, to prevent skin breakdown and promote comfort. They had not been notified of Resident #71's refusal of care on 8/20/2024. During an interview on 8/22/24 at 10:49 AM, the Assistant Director of Nursing stated residents should be checked and changed every 2 hours to help maintain skin integrity, decrease risk for urinary tract infections, and promote comfort. If a resident refused care, staff should notify the nurse. They should reapproach the resident or another staff member should try. 10NYCRR 415.12 (a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 44838 Based on observations, record review, and interview during the recertification survey conducted 8/19/2024-8/22/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice for 1 of 1 resident (Resident #3) reviewed. Specifically, Resident #3 did not have their elastic compression bandage (ACE wrap) applied as ordered. Findings include: The facility policy, Assistance with Compression Stockings, Wraps, and Other Compression Devices, dated 3/29/2016 documented aid with donning and doffing (applying and removing) compression stockings, wraps, and other compression devices would be provided to those residents who were unable to complete the activity independently. Compression wraps were specialized wraps used to improve blood flow in the legs by applying gentle pressure. Resident #3 had diagnoses including lymphedema (tissue swelling due to ineffective drainage by the lymphatic system), and localized edema (extra fluid in the tissues). The 7/13/2024 Minimum Data Set assessment documented the resident had intact cognition, did not reject care, and was dependent for lower body dressing. The 8/10/2023 physician order documented apply ACE wraps every day, on in the morning, off at bedtime every day and evening shift, with a start date of 9/1/2023. The comprehensive care plan initiated 9/1/2023 documented the resident had a self-care performance deficit and required extensive assistance of staff for dressing. The care plan did not include the use of ACE wraps. The 8/19/2024 Physician #7 progress note documented the resident's bilateral lower extremity edema was chronic and had not worsened. The left was greater than the right with some lymphedema and the plan was to continue Bumex (diuretic, water pill) and ACE elastic compression wraps. The resident was observed at the following times: - on 8/19/2024 at 11:05 AM their ankles were swollen, and they were not wearing ACE wraps. The ACE wraps were on the dresser and the resident stated staff did not always apply them. - on 8/20/2024 at 9:23 AM sitting up in their wheelchair. They had bilateral lower extremity edema bilaterally and they were not wearing ACE wraps. The ACE wraps were on the dresser. - on 8/20/2024 at 1:07 PM they were not wearing ACE wraps on their lower legs. The resident stated they were not put on by staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/2024 Treatment Administration Record documented apply ACE wraps (elastic compression wraps) daily, on in the morning, off at hour of sleep daily. with a start date of 9/1/2023. The ACE wraps were documented as applied and removed as ordered 8/1/2024-8/20/2024. Licensed Practical Nurse #1 signed the Treatment Administration Record the ACE wraps were applied during the day shift on 8/19/2024 and 8/20/2024. During an interview on 8/22/2024 at 9:45 AM, Registered Nurse Unit Manager #2 stated resident care information was in the care plan and the computer. ACE wraps were applied by nursing. If ACE wraps were signed for, they should have been on. Resident #3 should wear ACE wraps every day for lower extremity edema as it helped to promote venous return. Excess edema could increase their risk for skin issues and improper clotting. During an interview on 8/22/2024 at 10:18 AM, Licensed Practical Nurse #1 stated ACE wraps were applied by the nurses, and if it was signed for in the Treatment Administration Record, they were applied. Resident refusals should be documented in the Treatment Administration Record or progress notes. Resident #3 had an order for ACE wraps due to edema and needed to be worn to help reduce the edema. They were not sure if they had applied the ACE wraps on 8/19/2024 or 8/20/2024. They stated if they signed for them, they should have made sure the wraps were on. 10NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48052 Based on observation, record review, and interview during the recertification survey conducted 8/19/2024-8/22/2024, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 2 of 2 residents (Resident #31 and #58) reviewed. Specifically, Resident #31 did not have a pillow between their left arm and body for pressure relief as care planned, and Resident #58 did not have pressure relief for their heels as planned. Findings include: The undated facility policy, Pressure Ulcer Prevention, documented the interdisciplinary team was to plan appropriate interventions to remove or modify risk factors that were modifiable and to monitor the impact of interventions and modify as appropriate. Staff was to use appropriate devices to offload pressure from heels that are at high risk. If a resident refused recommended care and treatment, the interdisciplinary team was to evaluate the reason for the refusal, identify potential alternatives, and implement alternatives as the resident allows. The undated facility policy, Resident-centered Standards of Care and Exceptional Care Planning, documented the facility would develop exceptional resident-centered care plans that were consistent with the resident's specific conditions, risks, needs, history, behaviors, preferences, and with current standards of practice to meet the resident's medical, nursing, mental, and psychosocial needs. It was the responsibility of the interdisciplinary team to implement and communicate the resident's plan of care. 1) Resident #31 had diagnoses including a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer of the left elbow and Alzheimer's disease. The 6/21/2024 Minimum Data Set (an assessment tool) documented the resident had severely impaired decision making ability, was dependent for all activities of daily living, had one Stage 4 pressure ulcer not present upon admission, had a pressure reducing device for their chair and bed, received pressure ulcer care, nutrition or hydration interventions, and applications of ointments/medications. The 7/19/2024 revised care plan documented the resident had a Stage 4 pressure ulcer to the left elbow. Interventions included a towel or pillow must be between the resident's left elbow and their body at all times. Evaluate the ulcer characteristics, presence of drainage, obtain cultures, measure the ulcer at regular intervals, monitor for signs of infection, provide wound care per the treatment order, and notify the provider if there were no signs of improvement with the treatment regimen. The resident care card (care instructions) documented a towel or pillow must be between the resident's left elbow and their body at all times. The 8/14/2024 Wound Evaluation completed by Registered Nurse Unit Manager #6 documented the resident had a Stage 4 pressure ulcer on the left elbow, was in-house acquired, and was stable. Treatments included dressings, cushion, foam mattress, incontinence management, moisture barrier, nutritional supplementation, and repositioning devices. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following observations were made of Resident #31: - On 8/19/2024 at 10:30 AM, the resident's left arm was slightly behind the resident's body in their padded wheelchair. The arm was slightly obscured by a blanket, the left shoulder was rotated slightly forward and there was no pillow or towel. between the left elbow and the body. - On 8/21/2024 at 9:26 AM there was a dressing on the left elbow. There was no pillow or towel between the resident's body and elbow. The resident's left elbow positioned against the side of the chair. - On 8/22/24 at 8:44 AM brought out of their room by Certified Nurse Aide #13 without a pillow or towel under their left elbow. The elbow was tucked against their body and against the curve of the wheelchair where the back meets the seat. During an interview on 8/22/2024 at 9:51 AM, Certified Nurse Aide #12 stated they knew what care a resident needed by looking at the care plan for each resident on their assignment prior to providing care each shift. Positioning and pressure relieving devices were on the plan of care. They stated Resident #31 had something on their elbow and the certified nurse aides had to position the resident a certain way, so the pressure was kept off their elbow. They assisted the assigned certified nurse aide to get the resident up with the mechanical lift that morning but was unaware if the resident had the care planned pillow between their body and their elbow. During an interview on 8/22/2024 at 10:04 AM, Certified Nurse Aide #13 stated they knew how to care for a resident by their care plan. They got their assignment and looked at the care plan for each resident. Pressure relieving devices were on the resident care card. They stated Resident #31 had heel cups for their heels and a pillow to hold up their arm in bed for pressure relieving devices. They put the resident's personalized picture pillow in the chair with the resident this morning and placed it between their back and their side in the chair to hold the resident up. They were not aware if the resident's care plan documented to put the pillow between their left arm and body, but they liked to put the pillow in the chair to assist in positioning the resident. It was important to apply pressure relieving devices as ordered so the resident's wound did not get worse. During an interview 8/22/2024 at 10:21 AM, Licensed Practical Nurse #17 stated that pressure relieving devices were applied by the certified nurse aides under the direction of the nurses and were on the resident's care plan. The certified nurse aides should put the pillow under Resident #31's left arm due to the wound on the left elbow. The pillow should be applied as care planned or the wound could worsen. During an interview on 8/22/2024 at 10:25 AM, Registered Nurse Unit Manager #6 stated pressure relieving devices were documented on the care plan and should be implemented by staff. If Resident #31's pillow between their left arm and their body was not applied, the Stage 4 wound on their elbow could worsen. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #58 had diagnoses including a Stage 2 (partial thickness skin loss) pressure ulcer of the right heel and pressure-induced deep tissue damage (purple or blue discoloration to intact skin due to underlying tissue damage) of the left heel. The 6/13/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not reject care, required partial/moderate assistance with bed mobility, was at risk for pressure ulcers, had 1 Stage 2 pressure ulcer, had 1 unstageable deep tissue injury, and had a pressure reducing device for their chair and bed. The 1/19/2024 physician order documented apply pressure relieving boots while in bed. The comprehensive care plan initiated 1/19/2024 and revised 1/31/2024 documented the resident had a deep tissue injury pressure ulcer to the left heel related to immobility. Interventions included a heel elevator cushion while in bed, administer treatments as ordered, monitor for effectiveness, and to only wear shoes for transfers and ambulation. The unsigned 8/14/2024 Skin and Wound Evaluation documented the resident had an in-house acquired left heel deep tissue injury measuring 0.7 centimeters by 1 centimeter with no drainage and the area was improving. The current treatment was to apply skin protectant and a heel cup (a foam adhesive heel protector) and use a heel suspension/protection device. The 8/2024 Treatment Administration Record did not include pressure relieving measures for the resident's heels. The following observations were made of Resident #58: - On 8/19/2024 at 12:06 PM, lying in their recliner chair with their legs elevated. Their heels were resting directly on the footrest. There was no heel elevator cushion or pressure relieving boot. - On 8/20/2024 at 9:12 AM, lying in their recliner chair with their legs elevated. Their heels were resting directly on the footrest. There was no heel elevator cushion or pressure relieving boot. - On 8/21/2024 at 9:25 AM, lying in their recliner chair with their legs elevated. Their heels were resting directly on the footrest. There was no heel elevator cushion or pressure relieving boot. Resident #58 stated they did not have a heel elevator cushion or pressure relieving boots and they did not elevate their heels while in bed or while lying in the recliner. During an interview on 8/21/2024 at 2:21 PM, Certified Nurse Aid #10 stated they provided care to Resident #58 during the day shift on 8/21/2024. The resident had wounds on their heels. Resident #58 did not have a heel elevator cushion or pressure relieving boots and when they provided morning care and got the resident out of bed, they did not elevate their heels. The heel elevator cushion was listed on the resident's care plan, and they were supposed to elevate their heels when the resident was lying down. It was important to follow the care plan and use the heel elevator cushion to prevent Resident #58 from developing new pressure ulcers and to avoid current pressure ulcers from getting worse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/2024 at 2:31 PM, Licensed Practical Nurse #15 stated when a resident had pressure relieving devices ordered it would usually be on the Treatment Administration Record and would also be included in the resident's care plan. They were unaware if Resident #58 had pressure relieving boots or a heel elevator cushion and they had not seen them being used or in the resident's room. They stated Resident #58 had pressures ulcers on their heels and they provided daily dressing changes. They stated it was important to use pressure relieving devices as ordered to prevent pressure ulcers from getting worse and if they were not used new areas could develop. During an interview on 8/22/2024 at 9:33 AM, Registered Nurse Manager #2 stated Resident #58 had pressure ulcers on their heels, and they were healing well. The licensed practical nurses provided daily dressing changes, and they were unaware if the resident had any pressure relieving devices. They stated if the resident was care planned for pressure relieving devices or had an order, they should have been implemented. They thought Resident #58 had a heel elevator cushion somewhere and they were unsure if they had pressure relieving boots. They stated it was important for Resident #58 to use pressure relieving devices as planned to reduce the friction on their heels and prevent new areas from developing. Their expectation was to be notified by staff if Resident #58 did not have pressure relieving devices so they could provide them. During an interview on 8/22/2024 at 11:05 AM, the Director of Nursing stated the registered nurse or provider would assess the resident and determine what pressure relieving devices were appropriate. They would write an order or update the residents care plan with specifics. They stated Resident #58 had pressure ulcers on their heels. If there was an order for pressure relieving boots and they were care planned for a heel elevator cushion they expected them to be used as planned. They stated it was important for Resident #58 to use the pressure relieving devices as planned to reduce the pressure on their heels and prevent new areas from developing. 10NYCRR 415.12(c)(1) 48675

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44838 48675 48895 Based on observation and interview during the recertification and abbreviated (NY0032236) surveys conducted 8/19/2024-8/22/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 or 2 meal test tray (the 8/20/2024 and 8/21/2024 lunch meals) reviewed; for 8 of 8 anonymous residents present at the Resident Council meeting, and for 6 additional residents (Residents #3, #35, #36, #44, #63, and #74) interviewed during initial screening. Specifically, the 8/20/2024 and 8/21/2024 lunch meals were not served at palatable and appetizing temperatures and were not flavorful. Additionally, 8 anonymous residents at the Resident Council meeting and Residents #3, #35, #36, #44, #63, and #74 stated the food was cold and unappetizing. Findings include: The undated facility policy, Campus Policy & Procedure: Temperatures, documented the service temperatures for a hot entree was 135-170 degrees Fahrenheit, cold beverages were 40-50 degrees Fahrenheit, and vegetables were 135-170 degrees Fahrenheit. During initial screening interviews on 8/19/2024, the following residents expressed concerns about the food served at the facility: - at 10:18 AM, Resident #74 stated hot food was not always hot enough. - at 10:44 AM, Resident #44 stated the hot food was not hot enough. The plates were heated, and the facility sometimes served sandwiches on them. - at 10:59 AM, Resident #3 stated the hot food was not hot. - at 11:05 AM, Resident #35 stated they did not like the food, it looked unappetizing and tasted poorly. - at 11:14 AM, Resident #36 stated hot food was not hot enough, and the scrambled eggs were cold. - at 11:36 AM, Resident #63 stated the food did not always taste good and was cold. During a Resident Council group interview on 8/20/2024 at 10:59 AM, 8 anonymous residents stated the food was cold and unappetizing. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/20/2024 at 12:09 PM, Resident #35 received their lunch meal tray that included meatloaf, mashed potatoes, and a cookie bar for dessert. The meatloaf was minced meat formed into a perfect half-sphere, the 2 scoops of potatoes were also half-spheres pushed together, and all items on the plate were covered with a thickened, gelatinous gravy. Resident #35 attempted to cut their cookie bar with their utensils and was unable to break the cookie into smaller pieces. The resident stated it was so hard they could not eat it. When they picked it up with their fingers, they stated it was too hard to chew. During a lunch meal observation on 8/20/2024 at 12:48 PM, Resident #103 was served their lunch meal tray. Their lunch tray was tested , and a replacement tray was provided. In the presence of Certified Nurse Aide #10 the spinach temperature was measured at 130 degrees Fahrenheit, the apple juice was 57.7 degrees Fahrenheit, the lactose free milk was 57.7 degrees Fahrenheit, and the water was 57.2 degrees Fahrenheit. The mashed potatoes and chopped spinach lacked flavor. During an interview on 8/20/2024 at 12:55 PM, Certified Nurse Aide #10 stated hot food should be served around 160 degrees Fahrenheit and cold food should be colder than 57 degrees Fahrenheit. It was important to serve food at the proper temperatures so that residents did not get sick. Residents liked hot food to taste hot, and cold food and drinks to be cold. During a lunch meal observation on 8/21/2024 at 11:57 PM, Resident #35 was served their lunch meal tray. The tray was tested , and a replacement tray was ordered for the resident. Certified Nurse Aide #11 was present for the temperature readings of the lunch tray. The hot chicken sandwich temperature was measured at 127 degrees Fahrenheit, and the gelatin was 57.2 degrees Fahrenheit. The bun for the chicken sandwich had hard edges on the bottom, and the meat was minced. Certified Nurse Aide #11 stated when they heated and served food to the residents it had to be hotter than 140 degrees Fahrenheit. During an interview on 8/22/2024 at 9:02 AM, the Director of Social Work stated Resident Council members had voiced concerns about the food. The Food Service Director came to the resident council meetings. The Director of Social Work stated they thought there were dietary concerns that were not addressed. During an interview on 8/22/2024 at 10:00 AM, the Dining Service Director stated they did test trays once a month. The test tray was completed to check for timeliness, temperature, accuracy, and palatability. They took the last tray from the cart; temperatures were taken, and the presentation of the tray was noted. They had received complaints about food and food service. They stated that food palatability was subjective. Food should be appealing to the eye, and enjoyable to eat. Food was expected to be serviced at appropriate temperatures. Service temperatures for hot food was greater than 135 degrees Fahrenheit and cold food was between 40 and 50 degrees Fahrenheit. Temperatures between 57 and 58 degrees Fahrenheit for cold beverages and 57.2 degrees Fahrenheit for gelatin were too high for service. The hot spinach temperature measured 130 degrees Fahrenheit and was borderline low. The chicken sandwich measured 127 degrees Fahrenheit and was low, but the holding temperature for the chicken was good when it left the kitchen, and it was placed on a bun. 10NYCRR 415.14(d)(1)(2)

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	335090	A. Building B. Wing	08/22/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48675 48895 Based on observation, record review, and interview during the recertification survey conducted 8/19/2024-8/22/2024, the facility did not ensure food was stored and prepared in accordance with professional standards for food service safety in the main kitchen. Specifically, in the main kitchen potentially hazardous foods were not cooled properly, there were several unclean areas, and the food storage areas contained unprotected food products. Findings include: The 3/1/2004 facility policy, Food Preparation and Storage, documented potentially hazardous foods requiring refrigeration must be cooled by an adequate method, so that every part of the product was reduced from 120 degrees Fahrenheit to 70 degrees Fahrenheit within 2 hours, and 45 degrees Fahrenheit or below within 4 additional hours. Foods particularly important to meet the requirements included gravies. Gravies should be stirred while the container was in an ice water bath at a depth of equal to or greater than the food depth. The 6/10/2024 facility policy, Food Service Sanitation, documented the facility would maintain the food service area in a clean and sanitary manner. All kitchen and kitchen areas were to be kept clean and free of litter. Kitchen surfaces not in contact with food would be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. The Food Service Manager was responsible for scheduling the staff for regular cleaning of the kitchen. Food service staff were trained to maintain cleanliness throughout their work areas during all tasks, and clean after each task before proceeding to their next task. The facility document, HACCP (Hazardous Analysis Critical Control Point) Cooling Log, did not document any food products cooled on 8/20/2024. The logs provided did not document any stock, sauces, rice, or gravy, only turkey, beef, pork, and chicken. The log provided columns for tracking the cooling time from the start time and temperatures noted initially, after 2 hours, and the final cooled temperature after 6 hours. These time frames did not allow for any corrective actions if an item did not meet the cooling requirements that were listed at the top of the tracking log sheet as: cool from 135 degrees Fahrenheit to 70 degrees Fahrenheit in 2 hours, and cool from 70 degrees Fahrenheit to 41 degrees Fahrenheit in the next 4 hours. 1. Improper Cooling of Potentially Hazardous Foods During an observation on 8/20/2024 at 11:24 AM, the three-door cooler beside the cookline contained a 6-inch quarter hotel pan covered with foil labeled, brown gravy 8/20, that was measured at 126 degrees Fahrenheit. During an observation on 8/20/2024 at 12:08 PM, the brown gravy temperature was measured between 124 and 128 degrees Fahrenheit by [NAME] #21 and confirmed by the surveyor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/2024 at 12:11 PM, the Dining Service Director stated the gravy would have been cooked by the morning cook who would have placed that in the cooler before lunch service. The proper cooling procedure was to get the food temperature down to 70 degrees Fahrenheit within 2 hours, and then another 2 hours to get the food temperature down to 40 degrees Fahrenheit. The kitchen staff should have been trained on that procedure. If the temperature had not changed in the cooler over the past 40 minutes, it would not meet the cooling requirements. They stated it should have been documented on the cooling log that was last completed on 8/13 by [NAME] #21 for a pork loin. The initial temperature was 171 degrees Fahrenheit, after 2 hours was 88 degrees Fahrenheit, and the final after 6 hours was 40 degrees Fahrenheit. The Dining Service Director stated they could not be certain the pork was cooled properly because their log did not provide enough information due to the lack of monitored temperatures. During an observation and interview on 8/20/2024 at 12:50 PM, the brown gravy in the walk-in freezer measured 100 degrees Fahrenheit. The Dining Service Director stated the gravy still did not meet the cooling requirements and would be voluntarily discarded. 2. Unclean Food Preparation and Storage Areas and Unprotected Foods The following observations were made in the kitchen and food storage areas on 8/19/2024: - at 9:29 AM, there was food debris, grease, and grime under and behind the cookline equipment. - at 9:31 AM, a hood filter was out of place. - at 9:35 AM, the walk-in cooler had debris on the floor under the food storage racks, and mold under the shelving and along the walls. The floor was very wet, and the ceiling was dripping condensation throughout the cooler. A rack of desserts (cake with whipped topping) was left uncovered in the middle of the cooler. - at 9:40 AM, the walk-in freezer had debris on the floor under the food storage racks. - at 9:41 AM, the dry food storage room had debris on the floor under the storage racks with cobwebs in the corner of the room. - at 1:46 PM, the old/unused kitchen walk-in cooler had two cases of shell eggs and some individual canned beverages. The shelving had a white moldy substance on it, and the floors were unclean. The following kitchen and food storage areas were observed on 8/20/2024: - at 11:12 AM, the old/unused kitchen walk-in cooler had unclean floors, and shelving with mold and food debris. At that time the cooler contained two cases of shell eggs, one case of beef top rounds, and two cases of raw chicken. The walk-in freezer had excessive ice building up in the doorway, on some cases of food product, the compressor fan, and the floors. - at 11:22 AM, the main kitchen floor was soiled under the cookline and preparation tables with dried on food debris, grease, and grime. - at 11:28 AM, 2 flies landed on multiple uncovered cake desserts, located next to the tray line. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- at 11:29 AM, the ice cream cooler (double door upright cooler) contained dried on food spills and debris. During an interview on 8/20/2024 at 12:16 PM, the Dining Service Director stated that the old kitchen walk-in cooler and freezer were used as a back-up. They rotated stock and checked the temperatures daily but did not clean those as often, probably about once a month. The main kitchen coolers were cleaned at least once a week. They stated that some of the cleaning was documented. The facility's most recent Cleaning List was dated 6/2 to 6/15 and documented the walk-in cooler was to have the shelving removed, racks, walls, and floors cleaned, and was not documented as completed. The ECM kitchen (old unused kitchen) was documented as having the walk-in cooler and freezer organized, swept, and mopped on 6/2/2024. The wall behind the cook area was cleaned on 6/10/2024, but sweep under all cooks equipment was not documented as completed. During an observation and interview on 8/21/2024 at 12:19 PM, the Dining Service Director observed and verified the old kitchen coolers were not clean. They stated that all kitchen preparation and storage areas should be kept clean for the health and safety of the residents. 10NYCRR 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44838 48052 Based on observation, interview, and record review during the recertification survey conducted 8/19/2024-8/22/2024, 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 infection for 1 of 2 residents (Resident #31) reviewed. Specifically, Resident #31's wound care was completed without appropriate hand hygiene, clean supplies, and precautions to prevent contamination of the wound. Additionally, three infection control policies were not reviewed annually as required. Findings included: The facility policy, Skin and Wound Infection Prevention, dated 3/1/2004, documented the facility would reduce the incident of skin and wound infections by utilizing accepted professional standards of care. The clean technique were strategies that were used to reduce the overall number of microorganisms or to prevent the risk of transmission of microorganisms from one place to another. The clean technique involved meticulous handwashing, maintaining a clean environment by preparing a clean field, using gloves, sterile instruments, and prevention of direct contamination of materials and supplies. Chronic wound management for a routine dressing change without debridement included handwashing, clean gloves, sterile supplies (including solution and dressing supplies) to maintain as clean once opened, and to use sterile instruments. Wound Care: Resident #31 had diagnoses including a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer of left elbow. The 6/21/2024 Minimum Data Set assessment (a health assessment tool) documented the resident had severely impaired decision making ability, was dependent for all activities of daily living, had one Stage 4 pressure ulcer that was not present upon admission, had a pressure reducing device for their chair and bed, pressure ulcer care, nutrition or hydration intervention, and applications of ointments/medications. The 7/19/2024 revised Comprehensive Care Plan documented the resident had a Stage 4 pressure ulcer to the left elbow. Interventions included a towel or pillow must be between the resident's left elbow and their body at all times, evaluate the ulcer characteristics, drainage present, obtain cultures, measure the ulcer at regular intervals, monitor for signs of infection, provide wound care per the treatment order, and notify the provider if there were no signs of improvement with the treatment regimen. The 8/16/2024 physician's order documented cleanse the resident's left elbow wound with wound wash, pat dry. Pack wound with 1/4-inch iodoform strips (dressing used to prevent infection and absorb drainage) using a sterile cotton tipped applicator and push the dressing into the depth of the wound. Apply skin prep (a protectant) to the peri-wound (skin around the wound), cover with an absorbent pad and hold in place with retention netting every day shift for wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound care observation on 8/21/2024 at 10:18 AM, Licensed Practical Nurse #17 obtained treatment supplies including a paper barrier, unpackaged gauze squares, a packaged absorbent pad, a bottle of wound wash, and iodoform packing strips. At 10:19 AM, Licensed Practical Nurse #17 placed scissors from the treatment cart on the unclean nightstand next to the folded barrier sheet. Licensed Practical Nurse #17 stated they had cleaned the scissors prior to the treatment. They placed the unpackaged gauze squares on top of the folded barrier. They washed their hands along with Registered Nurse Unit Manager #6 and put on disposable gowns. At 10:21 AM, Licensed Practical Nurse #17 placed the unpackaged gauze squares on the uncleaned nightstand then moved them and the scissors to the barrier sheet. Licensed Practical Nurse #17 put gloves on and removed the soiled dressing from the wound and discarded it in the trashcan. They removed their gloves and put on new gloves without performing hand hygiene. Registered Nurse Unit Manager #6 prodded around the wound with their gloved hand, sprayed the wound with wound wash spray and cleansed the wound with gauze squares without changing their gloves. They changed gloves, washed their hands, and put on new gloves. They cut the iodoform strip to size with the scissors from the barrier sheet, packed the iodoform in the wound with the cotton tip applicator, cut the end of the iodoform strip with the same scissors, and placed the absorbent pad and the retention netting over the wound. During an interview on 8/21/2024 at 2:19 PM, Licensed Practical Nurse #17 stated the first thing they did when preparing for a wound treatment was to gather supplies. All wound supplies were in the treatment cart which was kept at the nursing station. When they got to the resident's room with the supplies, they set the barrier sheet down on the over the bed table or the bedside dresser and laid all the supplies on top of the barrier. They did not think they put the unpackaged gauze onto the bare bedside dresser. If scissors were used in the treatment, they were cleaned at the nursing station and then again in the resident's room before they were. The scissors used for the iodoform packing strips were not cleaned again prior to use during Resident #31's wound care. If the scissors touched the iodoform strips that go into the resident's wound were not cleaned, the resident could get an infection. They stated they performed hand hygiene before they obtained the wound care supplies and then after they got into the resident's room before applying gloves. Licensed Practical Nurse #17 stated they were supposed to perform hand hygiene between glove changes after they removed the soiled dressing and then again after they completed the wound care treatment. They stated they had not done hand hygiene when they had removed their gloves after disposing of the soiled dressing and putting new gloves on. It was important to practice proper hand hygiene because if they did not, they could potentially cause an infection to the resident or themselves. During an interview on 8/21/2024 at 2:39 PM, Registered Nurse Unit Manager #6 stated the wound care supplies were supposed to be placed on a barrier sheet in the resident's room. The unpackaged gauze and scissors should not be placed on the unclean bedside dresser. The scissors were cleaned right before they were used and right after use. They stated they cleaned the scissors at the nursing station prior to bringing them to the resident's room and they should have cleaned them prior to using them in the resident's room. If the scissors and the unpackaged gauze were set on the unclean, bare bedside dresser it could cause an infection. The order for the wound care treatment was the nurse would wash their hands, put gloves on, put the disposable gown on, take the old dressing off, clean the wound, wash their hands, put new gloves on, place the new dressing, take their gloves and gown off, then wash their hands again. The nurses were supposed to perform hand hygiene and change their gloves after the old dressing was removed and before they cleaned the resident's wound. Hand hygiene should be performed during every glove change. If hand hygiene was not performed, the resident could get an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/2024 at 10:49 AM, the Assistant Director of Nursing/Infection Control Nurse stated the Registered Nurse Educator recently did handwashing educations with the staff by using glow germs and a black light for competency. They stated on the spot reeducations were completed if necessary. Hand hygiene during wound care should be done before starting, before and after glove use, and between clean and dirty dressings. If hand hygiene was not done, it could spread infection. To prevent infection a clean barrier should be used for all supplies, including scissors, and scissors should be cleaned before cutting iodoform packing. Facility Policies not reviewed annually: The facility policy, Antibiotic Stewardship, documented it was approved 11/2017. There was no reviewed or revised date documented since 11/2027. The facility policy, Infection Prevention and Control Program, documented it was last reviewed and/or revised 1/11/2023. There was no documented annual review. The facility policy, Skin and Wound Infection Prevention, documented it was approved 3/1/2004. There was no reviewed or revised date documented since 2004. During an interview on 8/22/2024 at 10:49 AM, the Assistant Director of Nursing/Infection Control Nurse stated their policies were developed by clinical services and the policies were supposed to be reviewed annually and whenever changes needed to occur. It was important to review the policies to make sure they were applicable and up to date. They stated the antibiotic stewardship and infection control surveillance policies were reviewed but the review date was not documented. 10NYCRR 415.19(b)(1) & 415.19(b)(4)