STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335053	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elcor Nursing and Rehabilitation Center	48 Colonial Drive Horseheads, NY 14845

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 18814 Based on observations, interviews, and record review conducted during an Abbreviated Survey (NY00339596, NY00342850, NY00343008), for six of six residents (Resident #6, #11, #12, #15, #16, and #23) reviewed, the facility did not ensure that the residents on multiple units were treated in a respectful and dignified manner. Specifically, Resident #6 stated staff do not like them and staff are not mean, but not nice either. Resident #11 was repeatedly ignored by a staff member during care when asking questions about their care, Resident #12's family member stated they overheard a staff member using foul language in the resident's presence, Resident #15 stated the Registered Nurse speaks nasty to them, Resident #16 stated that staff were not always respectful, and Resident #23 stated the nurse was nasty to them. This was evidenced by, but not limited to, the following: Review of the facility policy Resident Rights, revised 03/18/2024, revealed the policy aims to promote a resident-centered approach where residents are treated with dignity, respect, and sensitivity to their individual needs and preferences. 1. Resident #11 had diagnoses of paraplegia and depression. The Minimum Data Set Resident Assessment, dated 10/11/2024, documented that Resident #11 was cognitively intact. Review of Resident #11's current Comprehensive Care Plan included maintaining a friendly, pleasant, non-confrontation approach, demeanor, and attitude. During an observation on 11/06/2024 at 2:10 PM, Registered Nurse #1 entered Resident #11's room to complete a skin assessment. Resident #11 asked Registered Nurse #1 where they wanted to start and if they were checking the abdomen first. Registered Nurse #1 did not respond. Resident #11 asked how they wanted them to turn. Registered Nurse #1 again did not respond. Resident #11 stated this is what they (staff) do, they ignore the resident, they do not answer when the resident speaks, and act like the resident is not there. 2. Resident #15 had diagnoses including anxiety and severe depressive disorder. The Minimum Data Set Resident Assessment, dated 09/30/2024, documented that Resident #15 was cognitively intact. During an interview on 11/13/2024 at 12:45 PM, Resident #15 stated that they (staff) do not care. They also stated Registered Nurse #1 is a robot/android, speaks to them nasty, is short with them, not respectful, and acts like they do not care. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #16 had diagnoses that included severe depressive disorder. The Minimum Data Set Resident Assessment, dated 10/11/2024, documented that Resident #16 was cognitively intact. During an interview on 11/13/2024 at 11:55 AM, Resident #16 stated that they (staff) call them sweetie, honey, or baby, and they should not call them by those names. Resident #16 stated they (staff) talk down to them like they are a child, and some staff are snotty and stuck up. Resident #16 stated the nurses and aides have answered their cell phones multiple times in the middle of care, specifically when changing their incontinence brief. During an interview on 11/13/2024 at 2:05 PM, the Director of Resident Care Services stated no one should be called honey, baby, or sweetheart. The Director of Resident Care Services also stated they have spoken to Registered Nurse #1 about how they come across to residents and that they should respond to Resident #11's questions. During an interview on 11/13/2024 at 2:45 PM, the Assistant Director of Nursing stated new employees receive a handbook at orientation that includes resident rights (to be treated with dignity). 10 NYCRR 415.5

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 18814 Based on observations, interviews, and record review conducted during an Abbreviated Survey (NY00359178), for two (Residents #22 and #23) of three residents reviewed, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately, but not later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures. Specifically, the facility did not report allegations of abuse, neglect, or mistreatment involving Residents #22 and #23. The findings are: The facility policy Recognizing and Reporting Elder Abuse/Neglect - Criteria, revised 10/10/2024, included the results of all investigations must be reported to the Administrator or designated representative and to other officials in accordance with state law (including the state survey and certification agency). The policy included verbal and physical abuse. 1. Resident #22 had diagnoses including schizoaffective and bipolar disorders and malingering behavior (intentional act of exaggerating physical and psychological symptoms). The Minimum Data Set Resident Assessment, dated 11/05/2024, included the resident had moderate impairment of cognitive function. Review of statements obtained by the facility included: In a report titled Alleged Incident Date: 10/27/2024, the Assistant Director of Nursing documented that Resident #22 had reported to Registered Nurse Supervisor #1 that the nurse had the pulled them down the hall to their room on their stomach by their arms. Registered Nurse Supervisor #1 reported this allegation to the Director of Residential Care Services immediately. During an observation and interview on 11/04/2024 at 4:30 PM, Resident #22 had black and blue bruising to both knees. Resident #22 stated the nurse held their hands and dragged them down the hall on their stomach which caused the bruises on their knees. 2. Resident #23 had diagnoses including bipolar and conversion disorders (forms of mental illness). The Minimum Date Set Resident Assessment, dated 10/04/2024, included the resident was cognitively intact. Review of an undated and unsigned form titled Resident Interview and Observation revealed when Resident #23 was asked if staff, a resident, or anyone else at the facility had abused them, including verbal, physical, or sexual abuse, the resident's response was yes that they felt that the nurse had verbally abused them. The facility investigation, dated 11/08/2024, included that Resident #23 felt the Licensed Practical Nurse had verbally abused them. During an interview on 11/06/2024 at 3:00 PM, Resident #23 stated that they reported verbal abuse because the nurse is nasty and does not treat them appropriately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional interviews conducted on 11/06/2024 included the following: - At 8:40 AM, the Administrator stated they use the 2016 complaints manual and if the allegation is ruled out after two hours, the allegation is not reportable to New York State Department of Health. - At 11:05 AM, the Director of Resident Care Services stated they know they only have two hours to report, and after talking to staff, the allegation was unfounded and not reportable to New York State Department of Health. - At 11:20 AM, the Assistant Director of Nursing stated they interpreted Resident #22's and Resident #23's allegations as not reportable. - At 12:47 PM, the Director of Nursing stated that the definition of abuse included verbal and physical abuse, neglect, mistreatment, and misappropriation. They also stated if suspected abuse is reported, the investigation is started, and they have two hours to determine if abuse is suspected. If abuse is suspected, the allegation is reported to New York State Department of Health. If abuse is not concluded, the investigation is completed in 24 hours, and written up with the conclusion that abuse is not substantiated and not reportable. The Director of Nursing added that the 2016 (New York State) complaint manual is used (versus the federal guidelines). 10 NYCRR 415.4(b)(1)(i)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 18814 Based on observations, interviews, and record review conducted during an Abbreviated Survey (NY00333741) for six (Residents #16, #17, #18, #19, #20, and #21) of six residents reviewed, the facility did not ensure the environment remained free from accident hazards. Specifically, the facility did not ensure that all six residents who were identified as cigarette smokers had been assessed and care planned for safe smoking. This is evidenced by, but not limited to, the following: 1. Resident #16 had diagnoses including peripheral vascular disease and congestive heart failure. The Minimum Data Resident Assessment, dated 09/26/2024, documented that Resident #16 was cognitively intact. During an observation on 11/12/2024 at 8:05 AM, Resident #16 was seated in a wheelchair behind a stop sign on facility property, approximately 200-300 feet away from the facility, smoking a cigarette. During an observation on 11/13/2024 at 11:55 AM, Resident #16's cigarettes and lighter were in an unlocked drawer in their room, and an additional lighter was on the tray table. During an interivew at this time, Resident #16 stated that they put the cigarette butts in their pocket and then later give them to a family member to put in the garbage at home. 2. Resident #17 had diagnoses including peripheral vascular disease and heart failure. The Minimum Data Resident Assessment, dated 10/09/2024, documented that Resident #17 is cognitively intact. During an observation on 11/12/2024 at 8:20 AM, Resident #17 was observed seated in a wheelchair outside the facility door by the dumpsters, approximately 10-15 feet from the facility entrance. Approximately six cigarette butts were observed on the pavement by the dumpsters. 3. Resident #20 had diagnoses including cerebral infarction and conversion disorder with seizures or convulsions. The Minimum Data Resident Assessment, dated 10/12/2024, documented that Resident #20 is cognitively intact. During an observation on 11/04/2024 at 8:00 AM, Resident #20 was seated in a wheelchair approximately 10 feet from the Hickory [NAME] facility entrance smoking a cigarette. Four cigarette butts were observed on the pavement by the entrance. During an observation on 11/12/2024 at 8:10 AM, Resident #20 was seated in a wheelchair approximately 10 feet from the Hickory [NAME] facility entrance. A blanket was placed over their head and body with an opening at the face and mouth. A lit cigarette was sticking out of the opening. Five cigarette butts were observed on the pavement by the entrance. The facility was unable to provide any smoking assessments or care plans related to smoking for any of the six residents identified by the facility as smokers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/06/2024 at 9:20 AM, the Director of Nursing stated that receptables for cigarettes butts are not provided by the facility because smoking is not allowed on facility property. The Director of Nursing said safety assessments for smokers and care planning for safe smoking are not completed because the facility is smoke-free, and maintenance staff pick up cigarette butts. During an interview on 11/12/2024 at 8:20 AM, the Director of Resident Care Services stated Resident #17 is not supposed to be smoking there, and that the facility is a smoke-free facility. During an interview on 11/12/2024 at 8:30 AM, the Director of Nursing stated providing receptacles may encourage residents to smoke. The Director of Nursing approached Resident #17 and asked them where they put their cigarette butts. Resident #17 stated the butts were thrown on the ground outside. During an interview on 11/13/2024 at 3:15 PM, the Assistant Director of Nursing stated residents' smoking paraphernalia should be locked up in a metal lock box as that is what was usually done when there were designated smoking areas. Review of the facility policy No Smoking, effective 03/13/2018 and revised 05/17/2024, revealed smoking is forbidden in all indoor and outdoor areas of the facility for residents, staff members, and visitors. Review of undated Admission Agreements, dated and signed by Residents #16, #17, #18, #19, #20, and #21, revealed that effective 12/09/2016, new admissions will not be granted smoking privileges on the campus. If the resident is admitted after this date, and wishes to smoke, they will have to find a location off campus to do so. All cigarettes and other smoking materials will be locked in the nursing supervisor's office and will not be allowed to be kept in the resident's room. 10 NYCRR 415.12(h)(1-2)