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	04/10/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 33420 Based on interview and record review during the abbreviated survey (NY00329178), the facility did not ensure all alleged violations involving mistreatment, neglect, or abuse were thoroughly investigated or reported to the New York State Department of Health timely when required for 3 of 10 residents (Resident #6, 9 and 10) reviewed. Specifically, Residents #5 and 6 had physical altercations that were not thoroughly investigated and altercations involving Residents #5, 6, and 9 were not reported to the New York State Department of Health as required. Findings include: The facility's Abuse policy dated 6/14/2023 documented all residents would be free from abuse and all reports of resident abuse or neglect were to be promptly and thoroughly investigated. The facility's Incident/Accident Investigation and Evaluation Policy documented it was the policy of the facility to accurately investigate and evaluate incidents and accidents, and to document the occurrence, findings, actions taken, and outcomes in the medical record and on the Incident/Accident Quality Assurance form. Documentation was to ensure causative factors were identified, corrective actions were taken, and preventative care plan interventions were planned, monitored, and modified as necessary. Resident #5 had diagnosis including frontal temporal neurocognitive disorder (the result of damage to parts of the brain), pseudobulbar disorder (disorder that causes sudden and uncontrollable laughing or crying), and dementia. The 10/10/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment. Behaviors included trouble focusing, disorganized thinking, and wandering 4 to 6 days out of 7 days. The resident required assistance with most activities of daily living and was independent with ambulation. Resident #5's comprehensive care plan, initiated on 10/3/2023, documented the resident was at risk for wandering. Interventions included to engage the resident in meaningful activities and provide clear simple instructions. The resident had the potential to be physically aggressive and a history of harming to others. Staff were to monitor behaviors of being physically active or playing tag or jogging in the hall. When the resident became agitated, staff were to guide them away. Resident #6 had diagnosis including dementia and depression. The 10/24/2023 Minimum Data Set assessment documented the resident had moderate cognitive impairment, verbal behaviors, rejected care, did not wander, and required assistance with most activities of daily living. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's comprehensive care plan, initiated on 9/1/2023, documented the resident had impaired cognition. On 10/23/2023, the care plan was revised and documented the resident did not like other residents to enter their room and a stop sign was added to the resident's door to be on at all times. Resident #9 had diagnosis including dementia with depression. The 12/12/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not have behaviors, had impairments in both legs, used a wheelchair for locomotion and was dependent on staff for most activities of daily living. Resident #9's comprehensive care plan, initiated on 9/1/2023, documented the resident had impaired cognition and required extensive assistance with transfers. Incident #1 - Did not rule out abuse/neglect or care plan violation The 12/1/2023 progress note written by registered nurse #7 at 5:51 PM, documented Resident #5 went into Resident #6's room and hit them on the right hand. Resident #5 was redirected and placed on 15 minutes checks. The family, medical provider and Director of Nursing were updated, and staff continued to monitor. The 12/1/2023 Incident/Accident Report, written by Registered Nurse #7 at 5:23 PM, documented Resident #5 entered Resident #6's room and hit Resident #6 on the right hand. No injuries were observed for Resident #5 and Resident #6 was assessed without injuries. Resident #5 had wandering behaviors, would tap/hit other residents with an open hand when startled. Resident #5 was placed on 15-minute checks. Resident #6 was assessed without injury and a stop sign was placed on their door. Statements included in the facility's 12/1/2023 investigation documented: - on 12/1/2023 at 4:30 PM, certified nurse aide #8 documented while standing in the family room they heard yelling from Resident #6's room. They responded and Resident #6 reported Resident #5 came in their room, knocked things off their table and hit them on their arm. They notified registered nurse Supervisor #7. There were no further statements included in the facility investigation. There was no documented evidence the facility identified if Resident #6's stop sign was in place prior to the incident per the care plan update noted on 10/23/2023 to deter other residents from wandering into their room. Incident #2 - Did not rule out abuse/neglect and did not report to the New York State Department of Health Resident #5's progress note dated 12/25/2023 at 3:06 PM written by licensed practical nurse #12, documented Resident #5 became aggressive with staff and residents, striking out at them. The resident went into Resident #6's room, hit the resident, and threw their lunch tray across the room. Resident #5 left the room and continued to be aggressive with whoever was in the hall near them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the facility investigated the incident to rule out abuse/neglect, no evidence the residents were assessed, and no documentation the incident was reported to New York State Department of Health as required. Incident #3 - Did not report incident to the New York State Department of Health The 2/7/2024 progress note written by licensed partial nurse #14 at 11:38 PM, documented Resident #5 was shopping in other residents' rooms, took a phone away from another resident and touched another resident's arm resulting in a resident-to-resident altercation. There was no further documentation regarding the incident at 11:38 PM. The 2/7/2024 Incident/Accident report written by registered nurse #5 at 8:20 AM, documented a certified nurse aide reported Resident #5 was agitated that morning and tried to take items from other residents. Initially, Resident #5 tapped Resident #7 on the head as they were very vocal in the dining room. A certified nurse aide intervened, and Resident #5 proceeded to slap Resident #10 on the back and exited the dining room. Moments later, another certified nurse aide reported Resident #5 tried to take a baby doll from Resident #9 and when the resident would not give it up, Resident #5 slapped Resident #9 across the face. Statements included in the facility's 2/7/2024 investigation documented. - certified nurse aide #18 reported Resident #5 was ambulating in the dining room, approached Resident #9 and slapped them in the face. - Certified nurse aide # 19 reported while Resident #5 ambulated around the dining room they tapped Resident #10 on the shoulder, tried to take the baby doll from Resident #9 who would not let go. Resident #5 slapped Resident #9 in the face. The 2/8/2024 social worker #15's progress note at 10:55 AM, documented they were notified of recent behaviors exhibited by Resident #5 over the past several days. An altercation occurred on 2/7/2024 with Resident #9 in which Resident #5 was the aggressor slapping a resident across the face. Resident #5 had been noted to have a few other resident interactions, however none to be altercations. The resident had a history of taking items from other residents, wandering the unit, in/out of other resident rooms and tapping others including staff. Resident continued to be monitored for negative behaviors and the plan of care continued at that time. There was no documentation the incident was reported to New York State Department of Health as required. During a telephone interview on 4/3/2024 at 9:32 AM, licensed practical nurse #14 stated Resident #5 had many frequent aggressive behaviors. They followed facility protocol and if they wrote a note the resident was aggressive or abusive then that was what happened. If an incident occurred, they would notify the Supervisor, who completed the facility investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview via telephone on 4/3/2024 at 9:57 AM, licensed practical nurse #12 stated on 12/25/2023 they were working on the opposite side of the unit from Resident #6's room was located and one of the certified nurse aides (they did not recall who) approached them and reported that Resident #5 entered Resident #6's room and pushed the tray table on to the floor. Review of the progress documented Resident #5 hit Resident #6 and the nurse stated (they) probably did and Resident #5 went in to Resident #6's room all the time and would hit the resident in the arms and legs. Licensed practical nurse #12 went into the resident's room and checked Resident #6's arms and legs and did not see anything. They thought they called the Supervisor and did not recall who that was. They told the other nurse on the unit what the aides reported and returned to their side of the unit. They thought they wrote a statement and did not know if the incident was investigated or if the resident was assessed. During an interview on 4/3/2024 at 11:59 AM, registered nurse #5 Unit Manager stated registered nurses were responsible to complete Incident/Accident investigations and included in the investigation was a note of what occurred, what they did, what factors were involved and notification of the medical provider and family. Registered nurse #5 Unit Manager reviewed the Incident/Accident Report looking for those areas and reviewed the care plan. Once the report was completed, the Director of Nursing received the report to determine if abuse occurred. In 10/2023, Resident #6 was care planned to have stop sign outside their door to keep residents out of their room as they did not like anyone in their room. On 12/1/2023, Residents #5 and 6 had an altercation. Resident #5 went into Resident #6's room and hit them. The investigation was completed and as part of the investigation, the staff were expected to identify whether Residents #6's stop sign was in place prior to the incident. If the door sign was not in place that would be a care plan violation and that was to be identified and documented in the investigation. They thought they knew about the incident on 12/25/2023 and did not recall if they saw an incident report or investigation. After review, they were unable to locate an investigation of the incident. During an interview on 4/3/2021 at 2:00 PM, Director of Nursing #3 stated a reportable incident was when a resident had contact with aggression or allegations of fear were voiced. Slapping another resident would be reportable incident. The incident on 12/1/2023 was investigated, they reviewed the Incident/Accident report and did not recall if staff were interviewed to determine if the stop sign on Resident #6's door was in place prior to the incident. If the stop sign was not in place, that would be a care plan violation and they expected that to be identified in the facility investigation. They stated they did not feel the investigation was complete. On 2/7/2024, they did not report the incident to the New York State Department of health as required and thought they had. They were unaware of an incident occurring on 12/25/2023 and there was no documented investigation for that incident. 10NYCRR 415.4(b)

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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** 33420 Based on observation, record review, and interview during the abbreviated survey (NY00329178), the facility did not ensure adequate supervision was provided to prevent accidents for 1 of 7 residents reviewed (Resident #5). Specifically, Resident #5 experienced increased anxiety and aggressive behaviors towards Residents #4, 6, 7, 8, 9, and 10 and the facility did not ensure adequate supervision was provided to prevent behaviors directed towards others. Findings include: The 5/2019 Behavioral Symptom Management Policy documented all residents who display symptoms including wandering, physical abuse, pacing, restlessness, socially inappropriate, or disruptive behaviors will not sustain harm to themself or others. Interventions included to ensure the resident's physical and comforts needs were met, move to a less stimulated area when overstimulated, and provide diversional activities. The 11/2003 Incident/Accident Investigation and Evaluation policy documented adequate supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual resident's assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Resident #5 had diagnoses including frontal temporal neurocognitive disorder (the result of damage to parts of the brain), pseudobulbar disorder (disorder that causes sudden and uncontrollable laughing or crying), and dementia. The 10/10/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment. Behaviors included trouble focusing, disorganized thinking, and wandering 4 to 6 days out of 7 days. The resident required assistance with most activities of daily living and was independent with ambulation. Resident #5's comprehensive care plan, initiated on 10/3/2023, documented the resident was at risk for wandering and had the potential to be physically aggressive with a history to harm others. Interventions included engage the resident in meaningful activities including humor, carrying a baby doll, coloring, walking, and pet visits. Provide clear, simple instructions, and monitor behaviors when physically active, or playing tag or jogging in the hall. When the resident became agitated, staff were to guide them away. The 12/1/2023 facility Incident/Accident Report documented Resident #5 entered Resident #6's room and hit them on the right hand. The residents were assessed without injury. Resident #5 was placed on 15-minute checks. The duration of the 15-minute checks was not specified and was not added to the resident's comprehensive care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5's nursing progress notes documented the resident exhibited behaviors of trying to hit another resident (unidentified) on 12/2/2023; spraying Lysol into the guide that was on the medication cart and hitting the nurse on 12/4/2023; following Resident #7 and hitting them with a pair of pants on 12/5/2023 and hitting the nurse with a baby doll on 12/9/2023. The 12/11/2023 nursing progress notes documented Resident #5 wandered into the room where Resident #7 was, and Resident #7 hit them in the shoe with their cane. Resident #5 continued to wander the unit and approached a singing resident, tagged them over their eye, continuing to wander in and out of residents' rooms. Nursing progress notes documented further behaviors on 12/13/2023 when the resident pushed other residents in their wheelchairs, ran down the hall, and smacked a staff member in the face and on 12/18/2023, when the resident had increased agitation, took other residents' belongings, and attempted to leave, slamming various doors. Seroquel (anti-psychotic medication) as needed was administered. Resident #5's progress note dated 12/25/2023 written by licensed practical nurse #12 at 4:06 PM, documented Resident #5 became aggressive with staff and residents, striking out at them. The resident went into Resident #6's room, hit Resident #6, and threw their lunch tray across the room. Resident #5 left the room and continued to be aggressive with whoever was in the hall near them. There were no documented revisions to the resident's comprehensive care plan to address behaviors including adequate supervision, additional non-pharmacological interventions, or increased meaningful activities. Resident #5's 12/29/2023 progress note written by registered nurse #16 documented at 8:55 PM, Resident #5 entered Resident #7's room. Resident #7 held onto Resident #5's shirt, raised their cane, and hit Resident #5 on top of the head. The residents were separated, and 15-minute checks were started. On 12/29/2023 at 5:45 PM, the facility Accident/Incident investigation documented Resident #5 entered Resident #7's room. Resident #7 reported (the resident) always comes in my room and steals things, (the resident) bit me. Resident #7 then hit Resident #5 on the top of the head with their cane before staff were able to intervene. The residents were separated and remained on 15-minute checks. The facility would monitor both residents' activity to determine if their care plans needed further changing. Resident #5's comprehensive care plan did not document any changed to interventions to address behaviors. The 15-minute check documentation documented 15-minute checks were stopped on 1/2/2024. Resident #5's nursing progress notes documented: -on 12/29/2023 through 1/7/2024, the resident wandered. - On 1/8/2024, the resident was exit seeking, banging on doors and railings, and weeping on and off that shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 1/15/2024, the resident slapped another resident (unidentified) in the face. 15-minute checks were initiated for 72 hours. No documentation of the 15-minute checks from 1/15/2024 through 1/18/2024 were received when requested by the surveyor. Resident #5's nursing progress notes documented: - On 1/22/2024, the resident wandered in other residents' rooms and taking their belongings. - On 1/23/2024, the resident's care plan was reviewed with no changes. - On 1/25/2024, the resident struck Resident #4. Resident #5's comprehensive care plan was revised on 1/29/2024 and documented the resident was at risk for harm to themself or others. Interventions included, administer medications as prescribed, if the resident posed a threat to self or others notify the medical provider, allow the resident personal space, if wandering or pacing initiate visual supervision during the acute episode, offer alternatives and utilize diversional techniques. Resident #5's nursing progress notes documented: - on 1/30/2024, the resident slapped a staff member and on 2/4/2024, the resident hit and bit a staff member. - On 2/6/2024, the resident had behaviors towards staff and while in another residents' room, they tapped the other resident on the head and messed up their hair. On 2/6/2024, the resident's comprehensive care plan was updated and documented a new intervention to offer the resident to go to the gym. Resident #5's nursing progress notes documented: - on 2/7/2024, the resident was shopping in other residents' rooms, took a phone away from another resident and touching another residents' arm. - On 2/7/2024, Resident #5 had an altercation and slapped another resident across the face in the dining room while attempting to take the residents' baby doll (Resident #8). The 2/8/2024 Social worker #15's progress note documented at 10:55 AM, they were notified of Resident #5's recent behaviors exhibited over the past several days. An altercation occurred on 2/7/2024 with Residents #8 and 5 who was the aggressor and slapped Resident #8 across the face. Resident #5 had been noted to have a few other resident interactions, however none to be altercations. The resident had a history of taking items from other residents, wandering the unit, in/out of other resident rooms and tapping others including staff. Resident continued to be monitored for negative behavior and the plan of care continued at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2/8/2024 nurse practitioner #17's progress note at 1:41 PM, documented Resident #5 was seen for behaviors over the course of the last 4 to 5 days and staff described aggressive, unpredictable behaviors. The resident had been wandering in and out of other residents' rooms, tapping other residents and staff. Staff encouraged to continue with non-pharmacologic interventions and redirection as necessary. Resident #5's nursing progress notes documented: - on 2/26/2024, the resident was running in the halls, banging on resident doors. - On 2/27/2024, the resident was going into another residents' room, proceeded to throw water around the room, pull tissues out of the boxes, threw clothing around, and attempted to pull the resident out of their bed. Resident #5 was up all night, running in the hallways, attempting to go in other residents' rooms. Staff intervened and removed Resident #5 from the rooms. The resident continued to run the hallways. The resident continued to go into other residents' rooms going through their belongings. On 2/27/2024, the comprehensive care plan was revised and documented a new intervention to notify the medical provider when the resident became aggressive. The 2/28/2024 nurse practitioner # 17's progress note documented they did not see any point or indication to make any medications adjustments and staff were to continue with the medications and non-pharmacologic interventions. Resident #5's nursing progress notes documented: - on 3/1/2024, the resident was ambulating in the hallway and running at times running. Redirection was attempted. The resident's family took the resident for a walk and the resident enjoyed that. - On 3/2/2024, the resident was running through the halls and on 3/3/2024, the resident was wandering in and out of other residents. rooms. - On 3/5/2024 and 3/7/2024, the resident was pushing residents in wheelchairs and running in the hall. Redirection was successful. The 3/13/2024 facility investigation at 1:45 PM, documented Residents #5 and 8 fought over a pillow that Resident #5 took from Resident #8's room. Resident #5 grabbed Resident #6's right wrist. There was no documentation the care plan was reviewed or revised after the incident on 3/13/2024 with adequate supervision after the 15-minute checks were completed no documented evidence non-pharmacological interventions were attempted or meaningful activities were initiated. (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 observation on 3/13/2024 at 1:18 PM, Residents #4, 5 and 6 were in the dining room eating lunch. The residents were seated at different tables with multiple staff present. After lunch was completed, Resident #5 was observed ambulating in the hallway. The resident had on jeans and a tee shirt and appeared to be a visitor. They wandered in the hallway and in and out of the dining room alone without staff present. Resident #6 was in their room. The door was closed and there was a fastened stop sign across their door. The resident was in bed watching television and stated in an interview at that [NAME] sometimes unknown residents came into their room and sometimes staff tried to stop them and it continued to happen. During an interview on 4/3/2024 at 11:28 AM, certified nurse aide #17 stated Resident #5 was frequently on their assignment, was alert and not oriented and at times had nasty behaviors. The resident wandered in and out of other residents' rooms and they let the resident walk all the time. When the resident was aggressive, they just had to walk away and they did not know how to calm the resident down. The resident hit, kicked, and slapped other residents and staff. The resident had many incidents and at one time, Resident #5 tried to pull Resident #6 out of their bed. They stated they did not receive specific direction on interventions for the resident and was not sure how to handle the resident's behaviors. When the resident was on 15-minute checks, they were done for a couple of days. They stated at times they could calm the resident down, however if they were extremely agitated, nothing worked. When Residents #8 and 5 were involved in an altercation, the certified nurse aide walked around the corner and saw the residents yelling. Resident #5 slapped Resident #8 in the arm. The residents were separated and placed on 15-minute checks. The 15 minute checks were documented and when they ended, they were told to monitor (keep an eye out) for the resident. During an interview on 4/3/2021 at 12:40 PM, nurse practitioner #3 stated Resident #5 had frontal temporal dementia and did well when they were first admitted . After admission, their behaviors ramped up. They titrated the resident's medications that they were admitted on and that was initially effective. The resident's spouse was reluctant to give more medications to the resident. The resident was ambulatory and reactive, and they felt a lot of the resident's behaviors were due to the staff members' approach. They expected the staff to use non- pharmacological interventions including redirection, encouragement, meaningful activities, changing the environment, and removing triggers. Staff were to provide meaning full activities which included walks. Coloring was not a good activity for the resident as the resident did not have the attention span to color. Fifteen-minute checks were not effective as the resident was able to make it to the other end of the hall within 15 minutes especially when they were upset. If the resident was upset, they required close supervision and monitoring. If the resident had more positive stimulation throughout the day, they felt the resident would be able to be sidetracked from potential triggers. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/3/2021 at 11:59 AM, registered nurse #5 stated the responding registered nurses were responsible to complete all Incident/Accident reports and update the comprehensive care plans with new interventions after incidents. Registered nurse #5 was responsible to check the investigation for completeness and ensure the care plan was reviewed and interventions for abuse prevention were in place. They stated they tried to add new interventions for prevention with all incidents. Resident #5 had frontal temporal dementia, was independent with ambulation, was able to run, and liked to shop in other residents' rooms. Some days the resident was easily redirected. Resident #5 had many resident-to-resident altercations. They expected the care plan to have some form of monitoring in place for Resident #5 and if 15-minute checks were initiated, then some form of monitoring was expected after the checks were discontinued. They stated from 10/2023 through 1/29/2024 there was no documented evidence Resident #5's care plan was reviewed or revised with additional supervision or meaningful activities until 1/29/2024. During an interview on 4/3/2021 at 2:00 PM, Director of Nursing #3 stated the Director of Nursing, or Unit Manager were responsible to update residents' comprehensive care plans. After an incident, they expected the care plan to be reviewed and revised if interventions were needed. Documentation of the care plan review would be in the incident/accident report and best practice the nursing note. The care plan should have been updated after 15-minute checks were completed with preventative monitoring. Review of the comprehensive care plans was conducted, and the Director of Nursing and they identified there was no documentation of monitoring after 15 min checks were completed for the incident from 12/1/2023-1/29/2024. Resident #5 was now on continual behavior monitoring and it was documented in the nursing progress notes every shift. During a telephone interview on 4/10/2024 at 8:24 AM, the Activities Director stated the facility used a meaningful living approach with residents on the dementia unit. There were a lot of interactive sites on the unit for the residents to use including a laundry room and a baby room. There were also items on the walls to help with interaction activities. Resident #5 liked to walk around, was easily redirected, and had a short attention span. The resident had pet visits once a week, took walks with their spouse, they liked to dance, and went to karaoke and a music program that was offered weekly. Baby dolls were also available to carry around and they did not know how often that occurred and a more active approach worked best for the resident. The resident attended the gym as needed and had gone 4-5 times. When admitted to the facility, the resident colored and that worked briefly. If the resident wandered in and out of other residents' room, they were easily redirected. If you approached the resident and they smiled redirection worked if not smiling that approach would not work. Meaningful activities for wandering would be considered when they determined what the need was. 10 NYCRR 483.25(d)