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 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.

(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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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). 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. (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 2:15 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. 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 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)