STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335480	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chemung County Health Center - Nursing Facility	103 Washington Street Elmira, NY 14901

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18814 Based on observations, interviews, and record review conducted during an Abbreviated Survey (ACTS Reference Number: NY00343164), the facility did not ensure that all drugs and biologicals were properly stored in accordance with State and Federal Regulations for two of two medication carts reviewed. Specifically, the medication carts on the North and South halls of residential Unit 4 were observed on multiple occasions unsupervised and/or unlocked by multiple nursing staff. Additionally, residents identified by facility documentation as cognitively impaired and wanderers were observed self-propelling their wheelchairs on both halls by the medication carts during the observations. This is evidenced by, but not limited to, the following: The undated facility policy Medication Administration included during medication administration, the medication cart will be kept closed and locked when out of sight of the medication nurse. The cart must be clearly visible to the personnel administering medications and all outward sides must be inaccessible to residents or others passing by. Resident #2 had diagnoses including dementia. The Minimum Data Set Resident Assessment, dated 04/30/2024, documented that Resident #2 had severely impaired cognitive skills. Resident #5 had diagnoses including dementia and psychosis. Resident #5 was identified by the facility as a wanderer. The Minimum Data Set Resident Assessment, dated 06/27/2024, documented that Resident #5 had moderately impaired cognitive skills. Resident #5's current Comprehensive Care Plan included special medication caps on medication bottles and to ensure the medication cart is locked at all times when not in sight. Resident #6 had diagnoses including Alzheimer's disease. Resident #6 was identified by the facility as a wanderer with wander guard placement (wander management system which uses bracelets, sensors, and technology to alert staff when a resident tries to leave a safe area). The Minimum Data Set Resident Assessment, dated 08/20/2024, documented that Resident #6 had moderately impaired cognitive skills. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335480	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chemung County Health Center - Nursing Facility	103 Washington Street Elmira, NY 14901

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility Incident Report, dated 05/23/2024, revealed that at 8:30 AM (that day), a bottle of trazodone (anti-depressive medication belonging to Resident #2) 50 milligrams containing 55 tablets was found in a sock in Resident #2's room. One tablet was found in the hallway and that (per staff calculations) 4 tablets remained missing from the bottle. Suspected cause of the incident included that Resident #2 removed the bottle of trazodone from the medication cart. In a nursing progress note, dated 05/23/2024, Registered Nurse/Head Nurse #1 documented that Resident #2 was noted to have increased lethargy and was easily aroused when touched by opening their eyes, but immediately dozed right back off to sleep. Vital signs included a blood pressure (BP) of 90/55 and the Nurse Practitioner ordered an evaluation at the hospital. Resident #2 returned to the facility around 10:55 PM with slightly altered mental status. Observations and interviews on 09/24/2024 on residential Unit 4 included the following: a. At 9:30 AM, the medication cart on the North Hall was unlocked with no staff member in view of the cart and in an area where residents had access to it. b. At 12:00 PM, the medication cart on the South Hall was unlocked and no staff member in view of the cart and in an area where residents could access it. Licensed Practical Nurse #1 was approximately 100 feet away walking away from the medication cart. Resident #5 was observed self-propelling their wheelchair by the medication cart. During an interview at this time, Licensed Practical Nurse #1 stated they should have locked the medication cart, but had to get a blood pressure cuff for another resident who almost fell . c. At 3:55 PM, the medication cart on the South Hall was unlocked and in front of the doorway of resident room [ROOM NUMBER] and not in sight of the nurse. During an intervier at 4:00 PM, Licensed Practical Nurse #3 stated they should have locked the medication cart before walking away. d. At 4:05 PM on the North Hall, Licensed Practical Nurse #4 moved the unlocked medication cart to the doorway of Resident #2's room and entered the resident's room with their back to the medication cart. e. At 4:12 PM on the North Hall, Licensed Practical Nurse #4 left the unlocked medication cart in front of resident room [ROOM NUMBER] with a large enough opening for a resident to make their way to the front of the medication cart. Licensed Practical Nurse #4 was in the resident's room with their back to the medication cart. During an interview at this time, Licensed Practical Nurse #4 stated they thought the medication cart was tight to the door and a resident could not get to it. f. At 4:16 PM on the North Hall, Licensed Practical Nurse #4 left the unlocked medication cart in front of resident room [ROOM NUMBER] and went to the far side of the room out of direct sight of the medication cart. During an interview upon returning to the medication, cart Licensed Practical Nurse #4 stated they should have locked the cart before they left. During observation of medication pass on 09/24/2024 on Unit 4's North Hall from 3:55 PM to 4:16 PM, Resident #5 and Resident #6 were both self-propelling their wheelchairs up and down the halls and near the unlocked medication cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335480	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chemung County Health Center - Nursing Facility	103 Washington Street Elmira, NY 14901

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/23/2024 at 1:40 PM, Licensed Practical Nurse #5 stated that they had witnessed Licensed Practical Nurse #1 leaving the medication cart unlocked and that it was common practice on the 4th floor. During an interview on 09/24/2024 at 12:15 PM, Registered Nurse/Head Nurse #1 stated the medication cart should be visible to the medication nurse and locked at all times, including when administering medications. During an interview on 9/24/24 at 12:40 PM, the Director of Nursing stated that facility-wide training was provided to all nursing staff after the incident involving Resident #2. Training included locking the medication cart and that the medication cart must be in the nurse's line of sight at all times when on the units. 10 NYCRR 415.18(e)(1-4)