

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Chemung County Health Center - Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>18814</p> <p>Based on observations, interviews and record review conducted during an Abbreviated Survey (NY00346373, NY00361053, NY00369686, and NY00369760) for three (Residents #1, #2, and #5) of five residents reviewed, the facility did not ensure the residents' environment remained free of accident hazards. Specifically, Resident #1's bed was left in an unsafe position creating a fall hazard. Resident #2's bed was left in an unsafe position and fall mats were not placed per their care plan to prevent injuries in the event of a fall. Resident #5 was on aspiration precautions (steps taken to prevent inhalation of food/drink into the lungs) and was not supervised while eating. This is evidenced by the following:</p> <p>1. Resident #2 had diagnoses including dysphagia (difficulty swallowing) and hemiplegia (paralysis) affecting the right dominant side. The Minimum Data Set Resident Assessment, dated 11/25/2024, documented Resident #2 had severe impairment of cognitive function.</p> <p>Review of Resident #2's Comprehensive Care Plan dated 06/25/2024 and Certified Nursing Assistant Kardex dated 11/19/2024 revealed the resident was at risk for falls and required a low bed height when unattended and fall mats on either side of the bed. The Kardex included the resident was on a pureed/nectar thick liquids diet.</p> <p>Resident #2's medical orders, dated 07/15/2024, included puree texture, and nectar (thick) consistency for fluids.</p> <p>Review of a Resident Incident form, dated 11/18/2024, revealed Resident #2 had received 60 cubic centimeters of thin liquids (water) during medication administration (versus thickened liquids as ordered). Review of the facility investigation revealed that Resident #2 initially tolerated the fluids, then became flush in the face and had a small emesis.</p> <p>During an observation on 01/21/2025 at 12:30 PM Certified Nursing Assistants #1 and #2 elevated Resident #2's bed to highest position (approximately 3 feet from floor and well above the tray table), boosted Resident #2 up in bed, removed the right floor mat, and placed Resident #2's lunch tray on a tray table over the bed. Certified Nursing Assistants #1 and #2 left Resident #2's room with the bed in high position and no floor mat placed on the right side of the bed.</p> <p>During an interview on 01/21/2025 at 1:10 PM Head Nurse #1 stated that the bed had to be high to get the tray table in and the floor mat should be placed by the tray table on the floor.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335480
		If continuation sheet Page 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Chemung County Health Center - Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/21/2025 at 2:20 PM the Director of Nursing stated that unless mats are care planned not to be placed on the floor when the tray table is in place, the floor mats should have been on the floor. The Director of Nursing stated that bed height is specific to each resident and per resident preference.</p> <p>During an interview on 01/21/2025 at 2:25 PM Certified Nursing Assistant #1 stated that both mats should be down when residents are having meals in bed, and they were told the bed could be in high position so they can get the tray table in.</p> <p>During an interview on 01/21/2025 at 2:40 PM Certified Nursing Assistant #2 stated that for at least the past year when Resident #2 was eating (while in bed) their mat had not been placed on the floor (by the table) and their bed had been left in the high position.</p> <p>During an interview on 01/21/2025 at 2:50 PM Certified Nursing Assistant #3 stated that when they were trained, they were instructed to put the bed up a few inches and both mats on the floor.</p> <p>During an interview on 01/22/2025 at 11:40 AM Registered Nurse #1/Staff Development stated Certified Nursing Assistants are taught that beds have to be completely lowered to the ground if the resident is unattended. Registered Nurse #1/Staff Development stated that unless specified in the care plan, the bed has to be in lowered for all residents and both floor mats placed on the floor.</p> <p>2. Resident #1 had diagnoses including Alzheimer's disease and a history of falls. The Minimum Data Set Resident Assessment, dated 12/10/2024, documented Resident #1 had moderately impaired cognitive function.</p> <p>Resident #1's admission Comprehensive Care Plan dated 06/21/2024 did not include any guidance to the recommended bed height for the resident's safety.</p> <p>Review of Resident #1's Certified Nursing Assistant Kardex dated 07/03/2024 revealed instructions for the bed height to be in the lowest position.</p> <p>Review of a Resident Incident form, dated 06/24/2024, revealed that Resident #1 was observed on the floor between the beds. Resident #1 sustained a left forehead laceration, measuring 4.5 centimeters that required an emergency room evaluation and sutures. The facility's investigation included that Resident #1's bed was not in the low position as documented on the resident's Certified Nursing Assistant's Kardex. The investigation included that the tape used to indicate bed height (a process the facility uses to ensure a resident's recommended or preferred bed height is maintained) was still on the wall from the previous resident that was in Resident #1's room and the reason why the bed was left elevated.</p> <p>During an interview on 01/21/2025 at 10:00 AM the Director of Nursing stated that Resident #1 was a high risk for falls, and the facility could not determine who was responsible for leaving the bed at the wrong (elevated) height.</p> <p>Review of the facility policy Fall Prevention Measure for High-Risk Residents, dated March 2014, revealed to keep the bed in low position and may adjust height of bed to accommodate placing tray table/roll stand under bed for meal periods, and to assess the need for the bed to be in the low position.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Chemung County Health Center - Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Resident #5 had diagnoses including dysphagia. The Minimum Data Set Resident Assessment, dated 12/17/2024, documented Resident #5 had severe impairment of cognitive function.</p> <p>Review of Resident #5's Comprehensive Care Plan dated 08/15/2024 and Certified Nursing Assistant Kardex, dated 01/22/2025, included aspiration precautions, pureed/nectar thick liquids and supervision when eating.</p> <p>Review of Resident #5's medical orders dated 12/26/2024 revealed the resident was on puree texture foods and nectar (thick) consistency for fluids.</p> <p>During an observation on 01/22/2025 at 8:15 AM Resident #5 was eating breakfast in bed. There was no staff present in Resident #5's room or directly outside their door in line of sight.</p> <p>During an interview on 01/22/2025 at 8:30 AM Head Nurse #1 stated that supervision means the resident is to be checked periodically.</p> <p>During an interview on 01/22/2025 at 8:35 AM the Director of Nursing stated that supervision means that someone is with the resident at all times when they are eating. Resident #5 requires a one-to-one with staff during meals. In a follow up interview at 11:00 AM the Director of Nursing stated that Resident #5 received thin liquid coffee for breakfast earlier that day and ingested at least half of it. In another follow up interview at 2:45 PM the Director of Nursing stated that when staff call the kitchen for resident requests, the resident's name and room number should be provided.</p> <p>During an interview on 01/22/2025 at 2:20 PM Head Nurse #1 stated that they made the call for Resident #5's coffee but that the kitchen staff should check the resident's consistency order. Head Nurse #1 stated that the Certified Nursing Assistant should have checked the Kardex before providing Resident #5 with the coffee.</p> <p>During an interview on 01/22/2025 at 4:00 PM the Food Service Director stated the kitchen person who took the call for Resident #5 should have cross referenced to check if thicken liquids were required for Resident #5 before sending the coffee.</p> <p>During an interview on 01/22/2025 at 4:00 PM Resident #5 stated they had received coffee that was not thickened and that they drank the thin coffee because it is better without thickener in it.</p> <p>During an interview on 01/23/2025 at 9:50 AM Speech and Language Pathologist #1 stated that Resident #5's recommendation says supervision (in line of sight) during po (by mouth) intake and aspiration precautions.</p> <p>Review of the facility policy Aspiration Precautions, dated 07/13/2023, 2023, revealed that residents who require the need for supervision with po (by mouth) intake will receive the recommendation for Supervision following evaluation by the Speech-Language Pathologist. Procedures and recommendations included no food or drink to be left with the resident unsupervised, and the resident be in direction line of sight of staff during meals.</p> <p>10 NYCRR 415.12(h)(1)(2)</p>		