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	08/01/2025

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, record review, and interviews during the recertification survey conducted 7/28/2025-8/1/2025 the facility did not ensure sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service for 2 of 3 resident units (Units 1 and 3). Specifically, Unit 1's and 3's meal trays were consistently delivered after the posted scheduled mealtimes and concerns were identified with the effectiveness of meal preparation and other food and nutrition services. Deficiencies related to food and nutrition services were identified in F 809 Frequency of Meals/Snacks at Bedtime; F 812 Food Procurement, Store/Prepare/Serve; and F 814 Dispose of Garbage and Refuse Properly.Findings include:The Resident Listing Report, dated 7/28/2025, documented the facility's resident census was 117. The undated facility policy Dietary Staffing, documented the facility should maintain adequate and qualified dietary personnel, including management and support staff, to ensure that all meals and snacks were safely prepared, handled and serviced in a timely and person-centered manner. Staffing levels were determined based on the census, resident acuity, meal service model, and operational hours. The projected schedule for the week of 7/27/2025-8/9/2025 documented the following:- On 7/28/2025 there was one cook, one supervisor and five kitchen staff for the morning shift; one supervisor and three kitchen staff working the dinner shift; and one kitchen staff working 11:00 AM- 7:30 PM. - On 7/29/2025, there was one cook, one supervisor, and 3 kitchen staff for the morning shift. One kitchen staff called off for the morning shift and one kitchen staff did not report to work for the shift. The evening shift had one supervisor and three kitchen staff. - On 7/30/025 there was one cook, one supervisor, and two kitchen staff. Two kitchen staff called off for the morning shift. There were three kitchen staff working the dinner shift; and one kitchen staff working 11:00 AM- 7:30 PM on trays.- On 7/31/2025 there was one cook/supervisor and four kitchen staff working the morning shift; four kitchen staff working the dinner shift; and one kitchen staff working 11:00 AM- 7:30 PM. - On 8/1/2025 there was one cook, one supervisor, and four kitchen staff working the morning shift; four kitchen staff working the dinner shift; and one kitchen staff working 11:00 AM-7:30 PM.During an interview on 7/31/2025 at 11:02 AM, the Director of Social Work stated the current census was 113. They were the grievance officer for the facility, and they received a lot of concerns about mealtimes and dietary issues. There was a lack of staff in the dietary department, they were actively hiring for diet aides and a Food Service Manager. They had all hands helping to put trays together at mealtimes and certified nurse aides were consistently helping with the tray line. They stated during resident council they should have someone from dietary come to talk to the residents and address their concerns but recently there was no one available. During an interview on 7/31/2025 at 1:16 PM, Dietary Aide #15 stated they started their shift at 6:00 AM and start serving breakfast at 7:00 AM. There was one cook on duty for breakfast and lunch and only one cook on at a time. They start serving lunch at 11:00 AM. They were not sure when supper was served because they were finished with their shift usually between 3:00 PM and 4:00 PM. This was based cleaning needs because the kitchen was to be cleaned before they left. There were four dietary aides to serve each meal and included around 115-120 people to serve. The kitchen served two others on-site facilities, Assisted Living and Independent Living. (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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Sometimes when they were short staffed, certified nurse aides came to the kitchen to help serve the food. They stated they needed more dietary staff. The weekend meals were usually one-half hour late due to low weekend staffing. During an interview on 7/31/2025 at 1:34 PM, Lead Dietary Aide #16 stated they used to be a supervisor, but they just signed a new job title and worked 11:00 AM- 7:30 PM. They had on the job training on different aspects of the job. They stated lunch started serving at 11:15 AM and supper at 4:40 PM. The kitchen also cooked and prepared meals for the Assisted Living and Independent Living facilities. They had one cook for all three buildings. They stated it usually took 1.5 hours to serve the facility, and they were usually done by 5:45 PM-6:00 PM. They only had two servers for all three facilities. There was only one person who served the skilled facility and four people to do the tray line. They were short staffed and could not always get the job done adequately.During an interview on 7/31/2025 at 1:50 PM, the Food Service Manager stated they were acting as the Food Service Director. They stated they were the first cook and came in at about 5:00 AM. The morning cook recently left the position. The meal tray line started at 7:00 AM for breakfast and continued until 8:00 AM; lunch was from 11:15 AM-12:30 PM; and supper was 5:40 PM-6:00 PM. They stated they also worked on weekends as a cook. The meals were occasionally late. The latest the meals were served was one hour late and was due to short staffing. The maximum staffing was 6-7 kitchen staff on days, and 5-6 kitchen staff for evenings and did not include the cooks. There was one cook and one supervisor for every meal, every day. There was enough staff scheduled to get the job done if they all come in to work. They stated they serve two buildings (skilled and the assisted/independent living buildings) which was about 200 people between all the buildings. If there were 1-2 staff call outs, which happened daily, it made a significant impact on the dietary service. Certified nurse aides helped on the tray line, and they received on the job training by dietary staff. The training usually took half a shift. They had a regional Registered Dietitian, and they were waiting for a Food Service Director. The kitchen closed about 7:30 PM but staff stayed late if the meals were late. During an interview on 7/31/2025 at 2:33 PM, Food Service Manager/Certified Dietary Manager stated they were in this role for 3 years and was based out of Pennsylvania. They stated they assisted with training staff. This week one cook resigned and now only had one cook, so the supervisor was cooking. They stated it should take an hour to get the first to last carts delivered to the residents. The meal carts were sometimes late due to staffing issues. The ideal staff should be one cook and 7 diet aides. Recently, they had certified nurse aides helping in the kitchen, working the tray line and dish room.During an interview on 8/1/2025 at 1:09 PM, the Assistant Director of Nursing/Graduate Nurse #3 stated they help in the kitchen with meals. They have staffing issues in the kitchen. When staff call in for the kitchen, they had to all come together to ensure the resident needs were met, and if they had to help on tray line, they would. During a telephone interview on 8/01/2025 at 1:29 PM, Regional Corporate Food Service Director stated their role at the facility was Director of Culinary Services and they were at the facility once or twice a week. They were not aware they were listed as the Acting Director of Dining Services but assisted with directing the kitchen. The current Assistant Manager/Supervisor was recently promoted to supervisor. The dietary staffing was an issue, and their focus was hiring. They stated there was not enough staff for extras, but the facility met the minimal standards. The nursing staff were trained to assist with tray line. They stated there were times when the meals were late but was not aware of the irregular mealtimes and was told they had not been over 15 minutes late.10NYCRR 415.14(b)(1)(2)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews during the recertification and abbreviated (NY00385403) surveys conducted 7/28/2025-8/1/2025, the facility did not ensure residents had the right to a dignified existence for 2 of 3 units (First and Third Floors) reviewed. Specifically, the First floor meals were served more than 30 minutes late; the Third floor meals were served more than 30 minutes late, and dining table residents were not served together. Additionally, deficiencies were identified in sufficient dietary support personnel to safely and effectively carry out the functions of the food and nutrition service (F802) that led to an undignified dining experience.Findings include:The undated facility policy, Dining Experience Policy, documented meals would be served at consistent, scheduled times, with flexibility for alternate meal schedules. Communal dining was encouraged for socialization. The undated facility policy, Dignity, documented meals would be served in a manner that maintained dignity and avoid treating residents as a task and resident would be encouraged and supported to make choices about their daily schedule, meals, activities, and care. The undated facility document, Cart Delivery Times, posted on the window of the third-floor kitchenette documented breakfast carts came at 8:00 AM and 8:10 AM, lunch carts came at 12:20 PM and 12:30 PM, and dinner carts came at 6:00 PM and 6:10 PM. The first-floor breakfast carts came at 7:40 AM and 7:50 AM, lunch carts came at 12:00 PM and 12:10 PM, and dinner carts came at 5:40 PM and 5:50 PM. During an interview on 07/28/2025 at 11:17 AM, Resident #97's family stated the meals were coming later. During an interview on 7/28/2025 at 12:05 PM, Resident #13's family stated food service was very delayed. On 7/27/2025, the family was present with Resident #13 and dinner was not served until 8:00 PM. There were times lunch was not served until 3:00 PM when shift change was occurring. The family stated they come to have lunch with the resident but may have to do this less frequently due to the timeliness of meals. They sat around for hours waiting for the meal to be served. During a resident group meeting on 7/28/2025 at 2:38 PM, seven anonymous residents stated the meals were served late. They were served dinner at 7:20 PM and 6:30 PM. The kitchen did not have enough staff for the 120 meals they had to prepare. The facility asked certified nurse aides to assist in the kitchen and that took staff away from the residents that needed assistance on the units. During a lunch meal observation on 07/28/2025, the lunch meal was served on first floor at 1:10 PM. The following observations were made during a Third floor lunch meal observation on 7/28/2025:- at 11:42 AM, staff started bringing residents to the dining room for lunch.- at 12:39 PM, Resident #97 was talking to their family and asking if lunch was coming and hoping it would be there soon. The resident was sitting outside the dining room with an empty tray table in front of them.- at 12:44 PM, there were no meal carts on the third floor. - at 12:51 PM, no beverages or snacks were served.- at 1:00 PM, the first meal cart was delivered to the unit.- at 1:02 PM, the first meal tray came off the cart and staff obtained beverages for the tray which was taken out of the dining room.- at 1:05 PM, the first meal tray was served in the dining room to table 5. Staff at the tray cart were looking for another tray to serve the same table. The staff was overheard stating the cart was not stocked per table. - at 1:06 PM, all members of table 5 were served. The meal cart was closed. Certified Nurse Aide #7 stated the cart did not have trays for complete tables, and they would have to wait for the second cart to serve the tables together. - at 1:11 PM, there were 7 staff members standing in the front of the dining room, no trays were served. 3 residents were eating, and 33 were not yet served.- at 1:13 PM, the second meal cart was delivered to the unit. - at 1:14 PM, Resident #87 was served their meal, staff removed the entree and told the resident they needed to get a replacement entree for them.- at 1:17 PM, Resident #87's meal ticket was returned to their tray.- at 1:23 PM, Director of Nursing #2 observed the staff pass trays, and verbally noted the last tray on the cart being served.- at 1:29 PM, Resident #87 was served their entree. During a dinner meal observation on 7/28/2025, the dinner meal was served on the First floor at 6:20 PM. The following observation were made during the Third floor dinner meal on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/28/2025:- at 5:24 PM, Licensed Practical Nurse Assistant Director of Nursing #3 was on the third floor and asked staff to go to the dining room. No staff were present in the dining room with 25 residents waiting for their dinner.- at 6:09 PM, the first meal cart was delivered to the unit. Director of Nursing #2 and Licensed Practical Nurse Assistant Director of Nursing #3 were on the unit to help with passing trays.- at 6:12 PM, Director of Nursing #2 stated the carts were not organized as they should be. They stated they knew residents should be served together, but the carts were not set up to do that. They were going to serve the meal trays as they were loaded into the meal cart. They stated they knew this would mean that some residents at one table would not be served at the same time as their tablemates. The remaining residents at the table would have to wait for their meal cart to arrive before they were served.- at 6:17 PM, the first cart was served. Resident #44 was waving for staff and repeating their name while pointing to the meal cart. The other three residents at the table were served their meal, but not Resident #44. Staff told Resident #44 more food was coming.- at 6:19 PM, Licensed Practical Nurse Assistance Director of Nursing #3 removed the seating chart from the wall and stated tables 7, 8, 9, and 10 could come on the second cart as they needed more assistance. - at 6:23 PM, the second meal cart was delivered to the unit. - at 6:24 PM, Resident #44 was served their meal.- at 6:30 PM, all meal trays were served. During an observation on 7/30/2025, the first breakfast tray was delivered to the Third floor at 8:38 AM. During a lunch meal observation on 7/30/2025, the lunch meal service started at 12:28 PM, and all trays were served by 1:00 PM. The following observations were made during the Third floor lunch meal on 7/30/2025:- at 12:51 PM, Resident #87 was served their meal and began eating while Residents #72 and #62 at the table were not yet served. Resident #72 tapped on the table and said, right here, can you get mine right here. - at 12:52 PM, One resident at table 6 was served their meal, the two other residents at the table were not yet served. - at 12:52 PM, Resident #72 was served their meal. Resident #87 had completed about 75% of their meal.- at 12:54 PM, Resident #62 was served their meal. Resident #106, from the neighboring table completed their meal and was saying good-bye as they exited the dining room.- at 12:57 PM, Resident #106 ate 100% of their meal before exiting the dining room. During an interview on 7/31/2025 at 10:42 AM, Certified Nurse Aide #19 stated the tray service was difficult. They had to pour beverages in paper cups because they were coming in prepackaged containers, like milk cartons and small plastic containers with tin foil lids. Beverage used to come in hard plastic dining cups. They stated the kitchen did not have enough staff to do the dishes, so they used the paper cups. The meal carts did not match the seating chart. Trays on the carts could be for the residents who ate in the hallway or the dining room. It was not dignified to serve some of the residents and not the whole table at once. They tried to gauge whether to serve the cart as it came or wait for the second cart and serve the whole table together. They sometimes had to move the residents around from table to table so they could serve the residents together if only one cart was on the unit. They had to think about the benefit of the resident, serve cold food or serve what was available regardless of the seating chart. There was a day lunch did not come until the second shift was coming in, about 3:00 PM. During an observation and interview on 8/1/2025 at 8:39 PM, Certified Nurse Aide #7 stated since the former dietary manager left the facility a few months ago there were meal service issues. They spoke with members in Administration and Corporate team, but no changes or education was done. The meals were always late, at least 30 minutes daily, and weekend meals were more than an hour late. The two meal carts came to the unit about 15 minutes apart. Breakfast was supposed to be served at 8:00 AM. At 8:44 AM, a meal cart was observed entering the dining room. Certified Nurse Aide #7 stated that cart was the second meal cart for the unit and should have been on the unit at 8:10 AM. They helped by bringing the tray carts back to the kitchen after meal service as the dietary department did not have anyone to come get them. During an interview on 8/1/2025 at 8:55 AM, Licensed Practical Nurse #12 stated the meals were always late. Breakfast usually came to the unit about 9:00 AM. The carts usually came about 10-15 minutes apart, and sometime longer than 15 minutes. The dietary department was short staffed. The tables should be served together, but sometimes they served the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents when each cart came regardless of the tray order, or they would wait for both carts because they did not always know when the second cart would come to the unit. The resident could have behaviors in the dining room with the delays. On the weekends, there were a couple times when the meal was about 2 hours late. During an interview on 8/1/2025 at 12:08 PM, Director of Nursing #2 stated they expected meals to be served on time. There were complaints from residents, family, and staff about food service. The biggest complaint was meals were not delivered to the floors timely. Nursing staff was helping the dietary staff in the kitchen. During an interview on 7/31/2025 at 1:16 PM, Dietary Aide #15 stated meals were usually 30 minutes late on weekends due to staffing problems. During an interview on 7/31/2025 at 1:34 PM, Lead Dietary Aide #16 stated there were times meals were an hour late due to short staffing. During an interview on 7/31/2025 at 1:50 PM, Food Service Manager #13 stated the meals were occasionally late when served to the residents. They did not want to serve undercooked food to the residents and low staffing was the cause for meals being late. They determined the loading of the meal trays based on how the tickets printed out by seat. They loaded the tables and then the room trays. The dietitian and nursing set up the table seating charts. They received the seating chart just before survey started this week. They were not sure why residents at the same table were not served together. It was not a dignified meal experience when tablemates were not served at the same time. 10 NYCRR 415.5(b)(1-3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews during the recertification survey conducted 7/28/2025-8/1/2025, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards in one (1) out of one (1) main kitchen. Specifically, the main kitchen was unclean, had damaged freezer storage equipment, improperly stored utensils, and improper storage of food products.Findings include: The undated facility policy Kitchen Cleaning and Sanitation, documented all surfaces in the kitchen and food preparation areas were to be cleaned and sanitized regularly to maintain a safe environment for food storage and preparation, and to ensure the prevention of foodborne illness and cross-contamination. The undated facility policy Refrigerator and Freezer Cleaning and Temperature Monitoring, documented the facility performed routine cleaning of all cold storage equipment and made sure it functioned properly. The food should be stored six inches off the floor.The undated facility policy Food Storage, documented the facility stored all food and food-related items in a sanitary and organized manner to protect food from contamination and spoilage per regulations. All items in the refrigerator should be covered, labeled, and dated.The following observations were made in the main kitchen on 7/28/2025 at 10:31 AM;-there was water on the floor under the steamer. -a heavy, black, greasy substance was on the floor under the cookline equipment. -there were multiple food products and residue on the floor and under the shelving in the walk-in cooler.-the walk-in freezer door was not closed properly, and several cases of food were stored on the floor. - an ice scoop was lying on top of the ice in the ice machine.The following observations were made in the main kitchen on 7/29/2025 at 11:45 AM:-the floor by the cookline was soiled with a black greasy substance under and around equipment.-the middle reach-in refrigerator was soiled with dried on food debris and liquid.-the floor and under shelving in the walk-in cooler were littered with packaging, food spills, and food debris. Some food products were uncovered, including a large, eight-inch hotel pan of mixed diced fruit with a serving utensil in the product.-the floor in the walk-in freezer had built up black greasy substance and food debris. The door was not able to close properly due to icing in the frame. - The floor in the dry storage areas had black grimy substance on it. Some food packaging and dropped food product were noted on the floor under shelving.During the tray line lunch observation, the first cart was not clean and had a white liquid inside the cart on the bottom. Staff were loading lunch trays into the cart. Food Service Manger #13 wiped up the white substance with a dry cloth, set the cloth down on the counter surface and used the same cloth to wipe out the second cart.During an interview on 7/29/2025 at 12:00 PM, Food Service Manager #13 stated that the cloth used to clean the white liquid from cart one was not put in any sanitizer or cleaning agent prior to wiping out cart two and should have been.During an interview on 7/30/2025 at 12:23 PM, Food Service Manager #13 stated the kitchen was usually cleaned at the end of the night, including the floors under the cookline. The walk-in cooler and walk-in freezer were swept and mopped weekly. They stated the ice scoop should not have been stored in the ice. They stated there should not have been spilled food or food debris under shelving or equipment, in equipment, or inside carts. They stated food product could not be stored on the floor. A food service equipment vendor came in and fixed the freezer door seal, but the door still iced at the bottom and was not closing properly. They knew this affected the freezer's ability to maintain temperatures.During a follow-up interview on 8/1/2025 at 9:50 AM, Food Service Manager #13 stated potentially hazardous foods should be dated, labeled, and stored in the walk-in cooler. They were supposed to use test strips to make sure the sanitizer levels were in range in the three-bay sink.During an observation on 8/1/2025 at 10:04 AM, Dietary Aide #18 was using the three-bay sink. They stated they were not taught how to test the sanitizer levels in the three-bay sink.During an interview on 8/1/2025 at 1:29 PM, Regional Director of Food Service #14 stated they assisted Food Service Manager #13 with kitchen oversight. Cleaning should be done routinely, including the floors under the cookline, the walk-in cooler and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	freezer, and under shelves. They stated education was provided this past week after the walk-in freezer door was left open. If the door was not closed properly the freezer temperatures and food product inside the freezer would be affected. They stated ice scoops should not be stored in the ice and food products should not be stored on the floor. They stated staff should be testing sanitizer for the three-bay sink, to ensure the sanitizer was effective, but they did not have enough staff for the extras right now.10NYCRR 415.14(h)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations, record review, and interviews during the recertification survey conducted 7/28/2025-8/1/2025, the facility did not ensure garbage and refuse was disposed of properly in one (1) of one (1) main kitchen. Specifically, the main kitchen garbage and refuse areas were not maintained to prevent attraction and harborage of pests.Findings include: The undated facility policy Garbage Disposal and Waste Management, documented all garbage, refuse, and waste was collected, stored, and disposed of in a manner that minimized health risk and prevented pest infestation. Kitchen waste was to be emptied multiple times a day. The exterior waste storage should be covered and secured to prevent pest access and kept free of overflowing waste. During an observation on 7/28/2025 at 10:40 AM, there were piles of trash and debris scattered on the ground around the dumpsters outside the main kitchen.During an interview on 7/30/2025 at 12:23 PM, Food Service Manager #13 stated the kitchen garbage was taken down the hall and put out the side door and into the dumpsters at the end of the night. They stated garbage should not be all over the ground near the dumpsters. If garbage was not disposed of properly and spilled on the ground, it could attract pests. During an interview on 8/1/2025 at 1:29 PM, Regional Director of Food Service #14 stated that kitchen dumpsters should be closed with no debris on the ground around them. They stated garbage should be emptied more often than it was, generally after each meal.10 NYCRR 415.14(h)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interviews during the recertification survey conducted 7/28/2025-8/1/2025, the facility did not ensure as needed orders for psychotropic drugs were limited to 14 days for one (1) of five (5) residents (Resident #14) reviewed. Specifically, Resident #14 had a physician order for as needed Ativan (anti-anxiety medication) that was not reevaluated for appropriateness or discontinuation after 14 days. Findings include: The undated facility policy PRN [as needed] Medication Administration Policy, documented special precautions were taken with psychotropic [as needed] medications, which required time-limited orders and clinical justification. Psychotropic medications were any drug that affected brain activities related to mental processes and behavior. All [as needed] orders must include the duration of the order (especially for psychotropics). [As needed] orders for psychotropic medications must be limited to 14 days, unless the attending physician documented and justified the need for continuation. The medications could not be renewed automatically and must be reassessed and re-ordered with the included rationale.Resident #14 had diagnoses including vascular dementia, paranoid personality and bipolar disorders. The 7/23/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment and received antipsychotics, antianxiety, and antidepressant medications.The Comprehensive Care Plan initiated 6/10/2025 documented the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. Interventions included the administration of medications and monitor for side effects and effectiveness.The physician order, created by Director of Nursing #2, and signed by Nurse Practitioner #9 documented Ativan 0.5 milligram with a start date of 6/20/2025 with the follow instructions:- give 0.5 tablet daily for agitation and anxiety disorder - give 0.5 tablet every 12 hours as needed for agitation and anxiety disorder - give 1 tablet daily for agitation and anxietyThe order did not include an end date. There were no documented revisions or renewals.The 6/17/2025 Licensed Pharmacist #11 Note to Attending Physician/Prescriber documented as needed psychotropics had a 14-day limitation on all as needed orders. Order may be extended beyond 14 days if the attending physician or prescribing practitioner believed it was appropriate to extend, documented clinical rationale, and provided specific duration of use. Please address Ativan use. Handwritten notes on the review form highlighted Physician #10 and under the area, Physician/Prescriber Response documented, stop after 14 days for PRN order, with a signature.The 6/2025 Medication Administration Record documented Ativan 0.5 milligrams every 12 hours as needed for agitation and anxiety disorder with a start date of 6/20/2025 and no end date. The resident did not receive an as needed dose of Ativan from 6/20/2025-6/30/2025. There were no medical provider progress notes documenting the resident was evaluated for use of as needed Ativan. The 7/15/2025 Licensed Pharmacist #11 Note to Attending Physician/Prescriber documented as needed psychotropics had a 14-day limitation on all as needed orders. Order may be extended beyond 14 days if the attending physician or prescribing practitioner believed it was appropriate to extend, documented clinical rationale, and provided specific duration of use. Please address Ativan use. There was no documented response from the physician or prescriber.The 7/2025 Medication Administration Record documented Ativan 0.5 milligrams every 12 hours as needed for agitation and anxiety disorder with a start date of 6/20/2025 and no end date. The resident did not receive an as needed dose of Ativan during 7/2025. During an interview on 8/1/2025 at 8:55 AM, Licensed Practical Nurse #12 stated Director of Nursing #2 was the former Unit Manager. The antipsychotic medications were reviewed every few months. Resident #14 had an order for routine and as needed Ativan. If the provider re-ordered the medication the start date would be the date of the re-order. The Ativan order was active since 6/20/2025. They were not sure if the as needed Ativan needed an end date, or who was responsible for adding that information to the order.During a telephone interview on 8/1/2025, Licensed Pharmacist #11 stated they completed the (continued on next page)

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	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Church Manor Nursing Home	863 Front Street Binghamton, NY 13905

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy medication reviews monthly. The pharmacy reviews were sent to the Director of Nursing. As needed medications were part of the monthly review, and as needed psychotropics should be limited to 14 days at most. If the resident had an as needed order for Ativan without an end date, that would be included on the recommendation given to the Director of Nursing. Once the recommendation was sent, it was the responsibility of the facility to follow through with the providers. During a follow up telephone interview at 11:54 AM, Licensed Pharmacist #11 stated the monthly reviews were sent to Licensed Practical Nurse Assistant Director of Nursing #3 who was the acting Director of Nursing for the facility.During an interview on 8/1/2025 at 12:08 PM, Director of Nursing #2 stated they were the Director of Nursing on record, but Licensed Practical Nurse Assistant Director of Nursing #3 was the acting Director of Nursing. Monthly medication reviews were done by the licensed pharmacy consultant every 3 months. The pharmacy recommendation papers went from the consultant pharmacist to the provider who signed off as agree or disagree with a note. The Unit Manager made any needed changes. Resident #14 had an as needed order for Ativan dated 6/20/2025, it was still an active order and was past the 14 day and should be reviewed. There was a note from the provider for the resident but was not a date to stop the Ativan after 14 days. The pharmacy review was scanned into the resident's record on 6/25/2025. The order was still active and was not stopped and should have been reassessed by the provider. During an interview on 8/1/2025 at 1:09 PM, Licensed Practical Nurse Assistant Director of Nursing #3 stated they helped the Unit Managers and worked with Director of Nursing #2 to train to be a Director of Nursing. The pharmacy consultant sent the reviews to the Director of Nursing. The provider made notes, the Unit Managers made the changes, and the unit clerk scanned the documents into the resident's record. Ativan had a 14-day reassessment requirement. There would be no potential for negative outcome from the resident as the nurses should be following the order and using appropriate nursing judgment.During a telephone interview on 8/1/2025 at 1:59 PM, Nurse Practitioner #9 stated the medication review papers came from the pharmacy and the Unit Managers distributed them to the providers. They often discussed these with the Unit Managers and checked agree or disagree on the form. The medications were reviewed quarterly. As needed Ativan re-order need depended on the indication for use. If the pharmacist made a recommendation and the provider agreed, they expected the change to be made.During a telephone interview on 8/1/2025 at 3:08 PM, Physician #10 stated the pharmacy consultant made recommendations and the Unit Managers gave the recommendations to the nurse practitioners to review. If they had questions, they contacted them to review. As needed Ativan should be reviewed and reordered every 14 days. If the pharmacist recommended a change and they documented they agreed to it, they expected the documented change to be completed. If the medication was reviewed for reorder, there should be a note with the reviewed information. It was important to review as needed orders as they may need to make changes if the medication was being used regularly, or to discontinue the medication if it was not being used. 10 NYCRR 415.4(a) (2-7)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interviews during the recertification survey conducted 7/28/2025-8/1/2025, the facility did not conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents competently both during day-to-day operations and emergencies. The facility did not review and update the facility assessment as necessary. Specifically, the facility assessment did not accurately reflect the clinical nutrition staff and department heads.Findings include:The 2024-2025 Facility Assessment documented the incorrect name of the Director of Nursing. The assessment documented the facility resources needed to provide competent support and care for the resident population every day and during emergencies. The assessment listed one Director of Nurses with a New York State license; 1 Director of Food and Nutrition which included Food service Director/ Diet technician/Registered Dietitian, Certified Dietary Manager, 3 cooks, and 6 food service aides. The registered dietitian listed was not full time or a department head, and the facility did not have a Dietary Director. During an interview on 7/31/2025 at 1:50 PM, Food Service Manager #13 stated they were full-time and not the department head. They also worked as a cook. They stated a regional staff person performed the Food Service Director job duties. During an interview on 7/31/2025 at 2:57 PM, Registered Dietitian #4 stated they work part-time at the facility and was hired for clinical duties only. They were not aware of any other responsibilities within the department. During an interview on 8/1/2025 at 12:08 PM, Director of Nursing #2 stated they were in the Infection Control (preventionist) position for about 3 weeks and was acting as the Director of Nursing while Assistant Director of Nursing #3 was training for the Director of Nursing role.During an interview on 8/1/2025 at 1:09 PM, Assistant Director of Nursing #3 stated their official title was Assistant Director of Nurse Trainee. Their badge documented GN/DON (Graduate nurse/Director of Nursing) trainee. They stated the official Director of Nursing on record was Director of Nursing #2. During an interview on 8/1/2025 at 1:29 PM, the Regional Director of Food Service stated they worked 2 days a week at the facility and was not aware they were listed as the Food Service Director. They stated they were under the impression they were assisting with directing the kitchen.During an interview on 8/1/2025 at 2:03 PM, the Administrator stated the Director of Nursing was also the Infection Preventionist and training the Assistant Director of Nursing. The previous Assistant Director of Nursing/Infection Preventionist left employment at the facility the week prior to survey. They were working with staffing agencies to hire qualified cooks. 10NYCRR 415.26

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the recertification survey conducted 7/28/2025-8/1/2025, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of six (6) residents (Resident #4) reviewed. Specifically, during Resident #4's wound dressing treatment Licensed Practical Nurse #8 did not perform hand hygiene when changing from contaminated to clean gloves. Findings include:The undated facility Wound Care Dressing Change, documented hand hygiene was required before starting the dressing change, after removing soiled dressings, and at the end of the procedure. Resident #4 had diagnoses including Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) left heel pressure ulcer. The 6/16/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment, an unhealed pressure ulcer, infection of the foot, received pressure injury care and application of dressings to the feet. Wound culture results obtained on 7/22/25 documented mixed flora and pseudomonas (bacteria) species.A 7/23/2025 at 12:41 PM Licensed Practical Nurse #20 progress note documented the wound culture was reviewed by Nurse Practitioner #9. A new order was provided to begin Cipro (antibiotic) 500 milligrams for 7 days. A 7/30/2025 at 7:55 AM Licensed Practical Nurse #21 progress note documented the resident continued on antibiotics for foot infection. The 7/2025 Treatment Administration Record documented Stage 4 left heel wound cleanse with wound wash, pat dry, apply zinc to peri-wound edges, apply Opticel AG (antimicrobial dressing with silver), cover with dry 4 x 4 gauze, secure with tape, apply heel cup every day shift. During a wound treatment observation on 7/30/2025 at 10:45 AM, Licensed Practical Nurse #8 performed a dressing change on Resident #4's left heel. Licensed Practical Nurse #8 removed the soiled dressing, removed their soiled gloves, did not perform hand hygiene, put clean gloves on, and applied the clean dressing.During an interview on 07/31/2025 at 10:38 AM, Licensed Practical Nurse #8 stated they should perform hand hygiene before and after the dressing change. They stated they changed gloves after the soiled dressing was removed. Hand hygiene was not necessary at that time because their hands had been in gloves and were clean. They stated that they should have hand sanitizer in the room to use between glove changes.During an interview on 08/01/2025 at 12:08 PM, Registered Nurse/Infection Preventionist #2 stated that per the facility procedure, hand hygiene was required after removing old dressings and removing the soiled gloves and before putting clean gloves on. They stated hand hygiene was critical before starting the dressing change, after removing the soiled gloves, and at the end of the dressing change as hands could be contaminated with organisms from the wound and could cross contaminated the clean dressing.10 NYCRR 415.19(a)(b)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on observations and interviews during the recertification survey conducted 7/28/2025 - 8/1/2025, the facility did not ensure one qualified individual, who was not the Director of Nursing, was responsible for the facility's Infection Prevention Control Program. Specifically, the Assistant Director of Nursing was not qualified based on education, training, experience or certification to assume the role of Infection Preventionist and the Director of Nursing assumed those duties.Findings include: The undated facility policy Infection Surveillance, documented the Infection Preventionist served as the leader of surveillance activities, maintained documentation of incidents, findings, and any corrective actions regarding infection control. They were responsible to report findings to the Quality Assurance Committee and public health authorities.The undated facility Emergency Phone Numbers form documented Director of Nursing #2 was also the Infection Preventionist. Assistant Director of Nursing #3 was the Director of Nursing in Training and the Assistant Director of Nursing.The 2024-2025 Facility Assessment documented the Infection Preventionist should be a New York State Licensed Registered Nurse.The 7/3/2025 Infection Preventionist certificate documented Director of Nursing #2 successfully completed the Centers for Disease Control and Prevention training course.During an interview on 8/1/2025 at 12:08 PM, Director of Nursing #2 stated they were in the Infection Preventionist position for about three weeks. Assistant Director of Nursing #3 was being trained for the role. If anyone requested to speak with the Director of Nursing, Assistant Director of Nursing #3 would talk with them and bring Director of Nursing #2 in as needed. The previous Director of Nursing terminated their employment on 7/3/2025. The previous Infection Preventionist terminated their employment about three weeks ago.During an interview on 8/1/2025 at 1:09 PM, Assistant Director of Nursing #3 stated they were training for the Director of Nursing role. They assisted Director of Nursing #2 with tasks but within their scope of practice. Director of Nursing #2 was the current Infection Preventionist, as they were not certified to maintain that position. They stated they had not yet passed their New York State Registered Nurse test, and the position required the holder to be a registered nurse in New York State.During an interview on 8/01/2025 at 2:03 PM, the Administrator stated Director of Nursing #2 was also acting as the facility's Infection Preventionist while training Assistant Director of Nursing #3, who was uncertified for the role. The regional office and management consulting team were responsible for verifying the credentials for staff holding those roles. The Administrator stated they were aware the Director of Nursing should not have any other responsibilities, and this was the reason they were training the Assistant Director of Nursing in the Infection Preventionist role. The previous Assistant Director of Nursing, who was the Infection Preventionist, terminated their employment with the facility on 7/29/2025. 10NYCRR 415.14(d)(1)(2)