STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335136	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loretto Health and Rehabilitation Center	700 East Brighton Avenue Syracuse, NY 13205

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification and abbreviated (NY00367212/446001) surveys conducted 8/25/2025-8/29/2025, the facility did not ensure a safe, clean, comfortable, and homelike environment for four (4) of fourteen (14) resident units ([NAME] Units 4, 5, 7, and 13) reviewed. Specifically, Resident #63 had dirty linens, and a soiled brief left at their bedside; Resident #187's room had a ceiling tile with a large brown stain and an unclean privacy curtain; Resident #314's room had a ceiling tile with a medium black stain; Resident #21's window shade had several brown spots; and Resident #373's wheelchair was unclean. Findings include:The 12/2018 Housekeeper job description documented job duties specific to housekeeping included cleaning walls and ceilings by washing, wiping, dusting, spot cleaning, disinfecting and deodorizing as instructed; and removing dirt, dust, grease, etc. from all surfaces using proper cleaning/disinfecting solutions.The facility policy “Cleaning and Disinfection/Non-critical care and shared equipment,” dated 7/22/2024 documented cleaning and disinfection of the facility, including resident rooms, was completed in accordance with environmental services policies and procedures. Privacy curtains were removed and laundered on a regular schedule, as needed, when soiled, and when a resident was removed from transmission-based precautions.The undated facility policy, “Safe and Homelike Environment,” documented the resident had the right to a safe, clean, and comfortable environment in which they received treatment and support for daily living. The facility policy “Wheelchair Cleaning, ” dated 10/1/2024, documented housekeeping staff did regularly scheduled cleaning of wheelchairs. Certified nurse aides would do daily inspection and cleaning after meals as needed. Additionally, any staff member may place an electronic work order at any time if cleaning was needed outside of the routine wheelchair cleaning schedule. The certified nurse aide placed chairs to be cleaned in the designated area. To clean the chair, remove all equipment from chair (cushions, leg rests, drainage bags, oxygen canisters, and personal devices); and remove the wheelchair seat cushion cover. Both seat cover and cushion needed to be disinfected, cleaned and dried separately. The cushions and covers were placed on a designated rack for proper drying prior to being placed back on the chair. The Wheelchair Cleaning Log sheet was completed and provided to the Housekeeping Manager/Operations/Manager/Designee.Fourth Floor Observations:During an observation on 8/27/2025 at 1:49 PM, Resident #63 was lying in bed and soiled linens and a soiled brief in a mechanical lift pad were on the floor next to the bed.During a telephone interview on 8/29/2025 at 9:51 AM, Resident #63’s family stated the resident’s room frequently has soiled briefs on the floor. They saw soiled linens on the overbed table when visiting. During an interview on 8/29/2025 at 10:43 AM, Certified Nurse Aide #43 stated they provided care for Resident #63 on 8/27/2025. The resident was incontinent and was normally changed after meals. They would take the resident back to their room and change the brief while the resident was in bed. The dirty wash clothes were hung on the side of the cleaning basin and the brief was rolled up at the end of the bed. Once the resident was changed, they put the wash clothes in the dirty linen holder and the brief in the trash. They never left them on the floor as it was not sanitary.During an interview on 8/29/2025 at 11:50 AM, Licensed Practical Nurse #42 stated incontinence products and linens should never be on the floor, it was a contamination and infection control issue. They should be rolled up and put at the end of the bed and discarded before going to the next resident’s room. They had to pick up incontinence products and dirty linens before. During an interview on 8/29/2025 at 12:02 PM, Licensed Practical Nurse Assistant Nurse Manager #41 stated soiled linens and briefs should not be on the floor, they should be disposed of, and the linens should go to the soiled linens bin. During an interview on 8/29/2025 at 1:12 PM, Registered Nurse Unit Manager #48 stated soiled briefs and linens should not be left on the floor, it was unsanitary. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fifth and Seventh Floor Observations:The 6/1/2025 – 8/29/2025 work order log for the 5th floor documented maintenance exchanged ceiling tiles twice on 8/1/2025, on 8/5/2025, on 8/6/2025, and twice on 8/27/2025. Housekeeping provided a privacy curtain on 6/4/2025, and three times on 8/14/2025. During an observation on 8/25/2025 at 10:50 AM, Resident #187’s room had a brown water spot on the ceiling tile in a circular shape about the size of a dinner plate. The privacy curtain had a large brown stain at the bottom corner. During an observation and interview on 8/25/2025 at 1:31 PM, Resident #314’s room had a black stain on the ceiling tile in a circular shape about the size of a wiffle ball. The resident stated the facility changed the tile and the stain came back.During an observation on 8/25/2025 at 1:26 PM, the seventh-floor small resident lounge had a metal bed flipped on its side and parts of the bed were located throughout the room. There were multiple wheelchairs in the room. During an interview on 8/28/2025 at 11:08 AM, Housekeeping Crew Leader #58 stated they went around to the rooms and looked at the resident’s privacy curtains to see if they needed to be replaced. They changed the curtains when they were dirty. The 5th floor and below were done regularly. They kept a record for privacy curtain replacement, but the paperwork was misplaced. They stated they washed about 20 in the last couple of days. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2025 at 3:08 PM, the Senior Director of Operations stated the small lounge was a resident area and the scattered electrical items were bed components on the floor. The repair should not have been made in a resident area. The bed and mattress should be removed from the floor and moved to the maintenance area until repaired.Thirteenth Floor Observations:The 8/2025 housekeeping logs for the 13th floor had a single line through room curtains. There was no documentation if the curtains were cleaned. During an interview on 8/26/2025 at 9:28 AM, Resident #21 stated there were several brown spots on both window shades. The resident stated they were embarrassed by them.During an observation on 8/26/2025 at 9:23 AM and 8/27/2025 at 12:44 PM, Resident #373’s navy blue wheelchair’s armrests were soiled with food particles. During an interview on 8/27/2025 at 12:49 PM, Housekeeper #60 stated they were responsible for cleaning resident wheelchairs in the morning, if they were in the hallway. There was no real schedule, night shift was doing it, but the Housekeeping Director waned them done in the morning. If the wheelchair appeared dirty, they knew to clean them. During an interview on 8/27/2025 at 12:59 PM, Certified Nurse Aide #61 stated if there was a dirty wheelchair they would clean it. Resident #373’s wheelchair armrests were dirty. They thought the night shift would have cleaned it before getting the resident up for the day. If the wheelchair was not on the schedule for cleaning that day, they would clean it when the resident went back to bed. All staff were responsible for cleaning resident chairs.During an interview on 8/28/2025 at 11:49 AM, Licensed Practical Nurse #47 stated staff should wipe down chairs if they notice them soiled. They had a schedule for each floor. Housekeeping typically cleaned chairs per the schedule and the certified nurse aides would put the chairs in the hall on the night shift. During an interview on 8/29/2025 at 12:02 PM, the Director of Maintenance stated they were made aware of the resident room ceiling tile on the 5th floor on a Friday about three weeks ago. They replaced it and by Monday the tile needed to be replaced again. They called the vendor for the leak and changed the tile again. There was a repair done, but it was a heating and cooling pipe, so the repair would require the system on that floor to be unable to heat or cool for approximately three hours at the minimum. The vendor had to come when the temperature was not going to be too hot outside. If housekeeping was unable to clean a window shade, they should order a new one. Once the new item came in, they notified maintenance to install the shade. They were not notified to install any window shades on the thirteenth floorDuring an interview on 8/29/2025 at 12:16 PM, the Director of Housekeeping stated staff had checklists to be completed daily for their room cleaning. Window shades were part of the deep clean, and they should be cleaned if dirty as part of the room cleaning. If the housekeeper was unable to get them clean, they should report it to the crew leader or them and they would attempt to clean it with something different. If they still were not clean, they would contact maintenance to have them replaced. They stated they were not notified of any additional cleaning needed or replacements for the thirteenth floor. The process for cleaning wheelchairs was on the 3rd shift schedule. They had a staff member that worked 4 days a week to clean chairs. Rooms assigned a deep clean got wheelchair cleaning also. If staff saw a dirty chair, they were expected to clean it when they saw it. 10 NYCRR 415.29(j)(1)

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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. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, record review, and interviews during the recertification and abbreviated (NY002586082/iQIES 446001) surveys conducted 8/25/2025-8/29/2025, the facility did not ensure food was served at palatable and appetizing temperatures in accordance with professional standards for food service for 9 anonymous residents and 2 of 2 test trays (8/27/2025 and 8/28/2025 lunch meals) reviewed. Specifically, the lunch meal test trays on 8/27/2025 and 8/28/2025 were not flavorful or served at palatable and appetizing temperatures; and 9 anonymous residents at the Resident Council Meeting stated the food was often cold, not flavorful, and overcooked. Findings: The facility policy Resident Meals, dated 1/2020, documented each resident received meals that were nourishing and palatable. Food and nutrition staff would monitor and audit food trays, so they were palatable, attractive, and served at a safe and appetizing temperature. A new tray would be issued if it was not. The undated facility policy Tray Service to Residents, documented the Dining Services Department would ensure food carts were docked on each floor at scheduled times. Test Trays were to be performed monthly. Nursing Services was to open the cart doors once the retherm (food reheating) cycle was completed. Trays were then delivered to the residents. During a resident council meeting on 8/26/2025 at 10:00 AM, 9 anonymous residents stated the food was usually cold, overcooked, and not palatable. During a meal observation on 8/27/2025 at 12:26 PM, Resident #528 stated they would not eat the meal as it did not look appetizing and looked overcooked on one side. The tray was tested for temperature and palatability with the following results: -roasted seasoned potato was 148 degrees Fahrenheit and had no flavor.-wax beans were bland.-pot roast was 126 degrees Fahrenheit, looked dry, and was dark brown on one side. -soup was 145.8 degrees Fahrenheit and had no flavor.-juice in a small plastic container was 61.7 degrees Fahrenheit.-gelatin with fruit was 52.5 degrees Fahrenheit. During a meal observation on 8/28/2025 at 12:11 PM, Resident #470's tray was used as a test tray, and a replacement was requested. The tray was tested for temperature and palatability with the following results: -soup was 153.9 degrees Fahrenheit and tasted bland.-hamburger was 143.3 degrees Fahrenheit and tasted warm.-potato salad was 50.9 degrees Fahrenheit.-coffee was 139.1 degrees Fahrenheit.-cranberry juice was 55.2 degrees Fahrenheit and tasted warm. During an interview on 8/27/2025 at 12:46 PM, Licensed Practical Nurse #8 stated residents had stated the food did not taste good. The nurse would then ask for an alternate from the kitchen. One resident told them the meat was just a hamburger in a pool of grease, and the resident was offered some soup. The units usually had the supplies to make a resident a peanut butter and jelly sandwich as a replacement. The kitchen prepared the food portions of the meal tray and unit staff prepared drinks separately. During an interview on 8/27/2025 at 1:37 PM, Certified Nurse Aide #28 stated they used to work in food service in the past. They were aware residents complained about the food being cold and not liking the consistency. The food looked overcooked and dry many times in the past. During an interview on 8/28/2025 at 9:10 AM, Registered Nurse Manager #4 stated they received frequent resident complaints about food. The complaints included the trays taking too long to get to the unit, the food being cold, and items missing from the trays. The residents' meal trays were set up in the kitchen by dietary staff. During an interview on 8/29/2025 at 12:45 PM, Dietary Aide #29 stated they prepared resident foods and brought the meal trays to the units. The cooks tasted the food while cooking. Food temperatures should be cold items below 40 degrees Fahrenheit and hot items above 140 degrees Fahrenheit. The food should be flavorful. During an interview on 8/29/2025 at 12:52 PM, Food Service Supervisor #30 stated tray audits were done on a daily and random basis and were documented. Audits included palatability. Test trays were done to ensure proper food temperature, palatability, and presentation. Cooking was done in the commissary and kitchen staff only plated the food. If the food did not look the way it should, kitchen staff should make the Director of the Commissary aware. They stated the acquired test tray temperatures were out of range. Soups were made on the units and that may be why they tasted bland. During an interview on 8/29/2025 at 1:09 PM, Commissary Director #14 stated they made the food, including the entrees, starches, eggs, and cereal. They also prepared the different consistencies. The food was cooked in the commissary, and the cooks should taste the food. Each meal was cooked 5 days in advance. The pot roast should have some liquid in the pan to keep it moist. The roast was precooked from a vendor and only sliced by the facility. Once the food was sent to the tray line and plated, the trays were placed on a cart, the cart was sent to the assigned unit, and the carts were placed in a machine to warm/heat the food. Each cart was placed in a machine, and the warming timer was set by dietary staff. The temperature differences may have been due to the food