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	03/10/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review during the abbreviated survey (2711290) conducted on 03/10/2026, the facility did not ensure residents with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one (1) of four (4) residents reviewed (Resident #2). Specifically, for Resident #2:- The 11/28/2025 Hospital Discharge Summary documented several pressure ulcers and recommended treatments. There was no documented evidence that the resident's skin was assessed upon admission and treatment orders were not obtained timely. - On 12/05/2025, nursing noted eight unstageable pressure ulcers (base of wound obscured by non-viable tissue; true depth could not be determined until tissue removed), and there was no documented evidence that physician ordered treatments were obtained for three of the pressure ulcers. - On 12/16/2025, nursing noted 10 pressure ulcers and there was no documented evidence that physician ordered treatments were obtained for five of the pressure ulcers. Findings include: The facility policy, Nursing Charting and Documentation, dated 10/21/2025 upon admission/readmission the following evaluations and assessments would trigger once automatically, unless otherwise noted, in the electronic record for nursing to complete: Nursing Admission/readmission Evaluation/Baseline Care Plan; Nursing Admit/Readmit every shift note; Pain Assessment; Fall Risk Evaluation; Self Administration of Medications; Braden Scale for Predicting Pressure Sore Risk; Elopement Evaluation, Tuberculosis Questionnaire; Functional Abilities; AIMS Evaluation; and Daily Skilled Observation/Assessment. The policy did not include a skin assessment. The facility policy, Skin and Wound-Pressure Injury Mitigation of Risk, Identification, Treatment and Documentation of Pressure Injury, dated 12/01/2025, documented Standards of Practice Pressure Injury Risk Mitigation Principles of Practice would be assessed and implemented upon admission/readmission, then weekly for the next 3 weeks, then quarterly or when there is a change in condition or return from the Emergency Room. This would be documented in the resident's record using the Braden Scale Assessment Tool and care plans would be placed in the chart with interventions based on the Braden Score. All residents with pressure injury on admission must be documented within the Skin and Wound module in the electronic record and reported to the provider and/or the Wound Care Nurse/designee and this information flowed to the 24-hour Report & Shift Report within the electronic record. When a resident develops a pressure injury during their stay, this must be reported to the provider or Wound Care Nurse/designee. Pressure injury must be placed in the electronic record within the Skin & Wound module and evaluated every seven days. Resident #2 had diagnoses including kidney cancer with metastasis (spread to other parts of the body), heart failure, and malnutrition. The 10/17/2025 Minimum Data Set assessment documented the resident's cognition was intact, they required partial/moderate assistance with rolling left and right and partial/moderate assistance with chair/bed-to-chair transfers. The resident had three unstageable pressure ulcers, one Deep Tissue Injury (pressure ulcer; purple/maroon discolored area or blood-filled blister due to damaged soft tissue) and Moisture Associated Skin Damage (erosion of skin from prolonged moisture from urine, feces, sweat or wound drainage). The 11/28/2025 Hospital Discharge Summary documented the resident had a wound on the sacrum (triangle-shaped bone in lower spine) and (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: 335136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	underwent surgical debridement (medical procedure that removes dead, damaged, or infected tissue) in the operating room on 11/21/2025. The resident had a wound vacuum assisted closure device (battery powered device used to accelerate healing) placed to the sacrum and they also had multiple other wounds. Wound care orders included:-to sacrum, cleanse with normal saline moistened gauze, pack cavity with a 4 x 4 gauze soaked in Vashe (antimicrobial treatment), cover with an abdominal pad and secure with tape daily and as needed. -to the buttock wound (report did not document which side), cleanse with normal saline moistened gauze, apply Aquacel AG (antimicrobial treatment), cover with dry gauze and an abdominal pad and secure with tape daily and as needed.-to both foot wounds, cleanse with normal saline moistened gauze, apply Aquacel AG, cover with dry gauze and an abdominal pad, and secure with gauze wrap daily and as needed. -leg wounds (location was not specified in the report), cleanse with normal saline, apply Mepilex (absorbent foam dressing), change every 2 days and as needed. The 11/28/2055 readmission Packet (facility document containing hospital record review for resident medical information prior to admission) documented the resident's pressure ulcers included: left lateral (to the side) heel, right heel, right lateral foot, left ankle, sacrum, coccyx (tail bone), left buttocks and the resident had a wound vacuum assisted device. The 11/28/2025 admission Assessment completed by Registered Nurse #7 documented the resident had impaired skin and to see Skin and Wound for updates. There was no documented evidence that the resident's skin was assessed upon admission in the Skin and Wound section of the resident's record. The 11/28/2025 physician orders documented:- a wound treatment, a wound vacuum assisted closure device to the sacrum and a dressing to be changed three times weekly.-offloading heel boots in bed at all times. There was no documented evidence of physician ordered treatments for the resident's other pressure ulcers documented in the hospital discharge summary and the facility's readmission Packet. The 11/28/2025 Comprehensive Care Plan documented the resident had potential for alteration in skin integrity. Interventions included turning and repositioning every 2-4 hours and as needed. There was no documented evidence in the Comprehensive Care Plan that the resident had an actual skin impairment. The 11/29/2025 at 3:14 AM, 7:17 AM and 10:35 AM Registered Nurse #8's Skin Issue notes documented 25 skin issues were not evaluated. The 11/30/2025 at 10:25 PM Registered Nurse #9's Skin Issue note documented 25 skin issues were not evaluated. The 12/01/2025 Nurse Practitioner #5 note documented the resident had multiple pressure ulcers and they continued with ordered preventative and treatment measures in place. The 12/01/2025 at 9:35 PM Registered Nurse #9's Skin Issue note documented the resident's right heel was unstageable and measured 4.6 centimeters wide x 3.7 centimeters long x 0 centimeters deep. Registered Nurse #9 documented:- on 12/02/2025 at 11:44 AM, 25 skin issues were not evaluated.- on 12/02/2025 at 3:21 PM, 25 skin issues were not evaluated. The 12/02/2025 physician orders documented:-to right and left heel pressure ulcers, apply Mesalt (highly absorbent dressing used for heavily draining or infected, moist, necrotic (non-viable tissue) wounds), cover with a gauze pad and wrap with gauze wrap daily. There was no documented evidence that the resident's left heel had been assessed prior to implementing a treatment order. The 12/05/2025 at 3:39 PM Registered Nurse #7's Skin Issue note documented:- the right rear hip blister measured 2.6 centimeters wide x 1.7 centimeters long x 0 centimeters deep.- the right gluteus (previously documented as the sacrum/coccyx) measured 7.5 centimeters wide x 9.6 centimeters long x 0 centimeters deep. - the left gluteus was unstageable and measured 16.9 centimeters wide x 11.2 centimeters long x 0 centimeters deep.- the buttocks had Moisture Associated Skin Damage and measured 9 centimeters wide x 9.3 centimeters long x 0 centimeters deep. -the left heel was unstageable and measured 9.2 centimeters wide x 6.4 centimeters long x 0 centimeters deep and had 100% eschar (black/brown, non-viable tissue).-the right 5th toe was unstageable, measured 2 centimeters wide x 2.9 centimeters long x 0 centimeters deep and had 100% eschar.-the right rear ankle was unstageable, measured 1-centimeter-wide x 1-centimeter-long x 0 centimeters deep and 100% eschar.-the right heel was unstageable, measured 6.6 centimeters wide x 7.7 centimeters long x 0 centimeters deep and had 100% eschar.-the right lateral ankle was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unstageable, measured 7.9 centimeters wide x 2.7 centimeters long x 0 centimeters deep and had 100% eschar. The 12/05/2025 physician orders documented:-to left buttock, cleanse, apply skin prep daily and offload when possible.-to non-intact blister right rear hip, monitor daily for dislodgement of scab, and for signs of infection. There was no documented evidence a physician ordered treatment was obtained for the resident's right lateral ankle, right rear ankle, and the right 5th toe. The 12/06/2025 at 6:48 PM Registered Nurse #8 documented the resident was sent to the hospital for conditions unrelated to their wounds. The 12/16/2025 Hospital Discharge Summary documented the resident's principal diagnosis during admission was fluid overload. The resident's wound vacuum assisted closure device was discontinued to their sacrum and new recommendations included to apply Santyl (wound treatment, removes dead tissue) to wound base, gently pack wound with lightly moistened gauze, and cover with dry gauze and an abdominal pad and secure with tape twice daily. There were no other documented wounds or recommended treatments on the Hospital Discharge Summary. The 12/16/2025 Skin Issues note completed by Registered Nurse #3 documented: -the left 5th toe was unstageable and measured 1-centimeter-wide x 3.5 centimeters long x 0 centimeters deep.-the left heel was unstageable and measured 9.9 centimeters wide x 6.1 centimeters long x 0 centimeters deep.-the left rear ankle was unstageable, measured 8 centimeters wide x 1.7 centimeters long x 0 centimeters deep and had 100% eschar.-the right 5th toe was unstageable, measured 1.5 centimeters wide x 3.3 centimeters long x 0 centimeters deep and had 100% eschar.-the right heel was unstageable, measured 5.5 centimeters wide x 5.6 centimeters long x 0 centimeters deep and had 60% eschar. -the right ankle amputation site was unstageable, measured 0.5 centimeters wide x 0.4 centimeters long x 0 centimeters deep and had 90% eschar. -the right buttock was a Stage 4 (full thickness wound with extensive tissue loss, exposed muscle, tendon, ligament or bone), measured 7.7 centimeters wide x 6.4 centimeters long x 0 centimeters deep and had 30% slough (non-viable tissue).-the right rear thigh had a blister measured 3.8 centimeters wide x 1.7 centimeters long x 0 centimeters deep.-the sacrum was a Stage 4, measured 3.1 centimeters wide x 2.3 centimeters long x 0 centimeters deep and had 30% slough.-the left buttock fold was unstageable, measured 4.4 centimeters wide x 4 centimeters long x 0 centimeters deep and had 90% eschar. The 12/17/2025 physician order documented treatments were implemented for the resident's heels, the left and right buttock and the sacrum. There was no documented evidence of a physician ordered treatment for the resident's right rear thigh blister, unstageable right ankle amputation site, unstageable left rear ankle, unstageable right dorsum 5th toe, and unstageable left dorsum 5th toe. During an interview on 03/02/2026 at 12:15 PM, Registered Nurse Clinical Coordinator #3 stated when wounds were found on assessment, orders should be implemented the same day. If orders were not on the hospital discharge paperwork, then they spoke to the facility wound nurse for recommendations. All wounds were reported in email to the wound nurse and the wound provider. On 12/16/2025, they just followed wound orders documented in the hospital report and any remaining areas without a treatment, they covered with a dry gauze until seen by the wound provider. During an interview on 03/02/2026 at 1:21 PM, Registered Nurse #7 stated that when a resident was readmitted , the admission assessment was done by a registered nurse, and the skin assessment was required to be completed withing 24 hours. If wounds were found, treatment should be implemented during the shift. If the hospital After Visit Summary had wound treatment recommendations, they were instructed by the facility to follow those recommendations and implement them after discussion with their provider. If a skin assessment could not be done on their shift, they verbally reported to the oncoming shift to complete. They recalled doing the resident's admission Assessment on 11/28/2025. The Skin and Wound application in the electronic record was fairly new, and they thought they had issues uploading information into the record that day. They were not sure why orders were not obtained and implemented for the resident's other wounds, and they expected orders would be more timely. On 12/05/2025, they did the resident's weekly wound assessment and stated a treatment should have been ordered for the resident's right lateral ankle, right 5th toe and right rear ankle. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/2026 at 10:58 AM, Registered Nurse #8 stated when a resident was admitted the skin assessment was to be completed within 24 hours and if it could not be done on their shift, it was passed on verbally to the oncoming shift to complete. Their note on 11/29/2025 at 3:14 AM was not documented by them as they worked the day shift. On 11/29/2025 at 7:17 AM and 10:35 AM, they had never documented a note where 25 skin issues had not been evaluated and they were not sure how those notes got in the record. During an interview on 03/05/2026 at 10:32 AM, Registered Nurse #9 stated ideally, a skin assessment was done during the shift the resident was admitted however they had 24 hours to do so. For a resident that was being readmitted , if there were skin issues that were being followed from the previous admission, if not resolved in the record, there would be a pop up that said skin was overdue and show that it was still in progress and not completed. Skin issues needed to be resolved before documenting the new skin assessment. They followed hospital wound care recommendations upon admission and if no recommendations were documented, they obtained an order usually based on their previous treatment orders. Orders should be obtained on the same day. On 11/30/2025 at 10:25 PM, they were not familiar with a note that documented 25 skin areas were not assessed by them. They had never seen that note before. They stated on 12/01/2025 and 12/02/2025, they were not on duty and did not write the notes documented in the resident's record. The resident should have ordered treatments to the areas. During an interview on 03/10/2026 at 10:53 AM, the Director of Nursing stated a head-to-toe assessment was completed within 24 hours of admission and a wound treatment implemented once the skin was assessed. A Braden Scale was done as well to determine what interventions to put into place. If at risk of pressure, the facility implemented preventative interventions. If a resident had actual pressure wounds, the wound nurse would be notified, treatments put in place, the certified nurse aide Task List (direct care instructions) would be updated with turning and positioning, a pressure reducing mattress and weekly skin assessments would be implemented. If the hospital made wound recommendations, the facility tried to ensure the treatments they had closely matched, and the wound nurse and wound provider would see the resident weekly. If an admission Skin Assessment could not be done on the shift the resident was admitted on , it was not done because of resident refusal or behavior. They expected the nurse to document the reason the assessment was not done and notify the next shift to complete. A medical provider should be called to get a verbal order for a treatment. The wound nurse and wound provider were involved with every pressure ulcer that was not a Stage 1 and they needed to monitor to determine if the right treatment was in place. They monitored weekly. Registered nurses on the unit did treatments and took pictures of wounds. On 11/28/2025, they could see in the resident's record that skin issues were documented as not evaluated. They did not see any pictures taken on 11/28/2025. They expected upon admission the resident would have a pressure mattress and offloading boots which were ordered. On 12/01/2025, when an order was obtained for the resident's left heel, they expected a documented assessment of the heel in the record. On 12/05/2025 and 12/16/2025, they expected treatment orders to be obtained for all of the resident's documented pressure ulcers or a rationale documented why treatment was not needed. 10 New York Codes, Rules and Regulations 415.12(c)(1)