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	04/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48446 48632 Based on observation, record review, and interview during the recertification and abbreviated (NY00321560, NY00315691, and NY00336003) surveys conducted 4/15/2024-4/23/2024, the facility did not ensure each resident was treated with respect and dignity in a manner that promoted maintenance or enhancement of their quality of life for 2 of 5 residents (Residents #384 and #414) reviewed. Specifically, Resident #384 sat in bed sheets soiled with vomit and was not cleaned in a timely manner and Resident #414 was not shaven, had unkept hair, and had an unclean room. Findings include: The facility policy Resident Rights & Notice of Resident Rights and Responsibilities reviewed 8/8/2022 documented residents would be treated with kindness, respect, and dignity. Resident rights included a dignified existence, to be treated with respect, kindness, and dignity, self-determination, privacy and confidentiality, and equal access to quality care. The facility policy Quality of Life-Dignity dated 1/10/2023 documented each resident shall be cared for in a manner that promoted and enhanced their sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem, and were treated with dignity and respect at all times. 1) Resident #384 was admitted to the facility with diagnoses including hemiplegia (one sided weakness), obesity, and diabetes. The 4/11/2024 Minimum Data Set assessment documented the resident was cognitively intact, required substantial assistance for bathing and toileting, and did not refuse care. The 3/24/2024 comprehensive care plan documented a self-care deficit related to fatigue. Interventions were to encourage the resident to participate in care. The resident was alert and oriented and able to make decisions regarding their care. The resident had an alteration in psychosocial well-being related to depression and anxiety and interventions including administering medications as ordered. The care instructions (Kardex) documented keep skin clean and dry and provide a homelike environment. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observations and interview on 4/16/2024 at 8:14 AM, Resident #384 was in bed with their call bell on. They stated they pushed the call bell at 7:30 AM and no one came so they vomited on the floor in to avoid vomiting on themselves. There was yellow liquid with food particles on the floor. At 8:22 AM licensed practical nurse #43 entered the room and stated they were going to get a basin for the resident. Licensed practical nurse #43 returned with a wash basin and gave it to the resident and started cleaning up the floor. The resident had vomit on the front of their tee shirt and on the bed sheets. Licensed practical nurse #43 did not attempt to clean or change the resident or their bed sheets. At 9:58 AM Resident #384 remained in bed. There were two large yellow spots on their bottom sheet. The resident stated that was where they vomited. During an observation and interview on 4/16/2024 at 3:13 PM Resident #384 was in their wheelchair in their room. The bed linen was not stained. The resident stated staff changed the sheet but did not wash them up and they would like a shower. The over bed table had a wash basin with yellow liquid covering the bottom. The resident stated they had vomited in the basin. During an interview on 4/22/2024 at 9:06 AM certified nurse aide #44 stated Resident #384 was cognitively intact. They stated last week the resident was not feeling well and was vomiting. If the resident stated, they put their call bell on at 7:30 AM that was believable because they often noticed call bells not being answered timely. They stated if a resident vomited and was not cleaned but the floor was it was not dignified. They stated they worked with this resident on several occasions and never observed them refusing care. During an interview on 4/22/2024 at 9:36 AM registered nurse Unit Manager #14 stated if they observed emesis on the bed and floor they would tend to the resident first, change the bed sheets, and then clean the floor. They stated if the floor was clean, and sheets were not it is not dignified, and residents should not have to sit in emesis. During an interview on 4/23/2024 at 9:28 AM the Director of Nursing stated they expected call bells to be answered in five minutes and anything over 15 minutes was unacceptable. Anyone could answer the call bell and tell nursing staff what the resident was requesting. If the bell was not answered residents could worry no one would answer their call bell. If a resident vomited, they expected the resident to be assessed, the resident to be cleaned, the nurse notified, the nursing supervisor notified, the bed changed, and the floor cleaned. They stated if the floor was cleaned and the resident was not and the sheets were left with vomit, it was not dignified. 2) Resident #414 was admitted to the facility with diagnoses including heart disease, central retinal vein occlusion (vein in the eye closes off), and malaise (generalized discomfort). The 2/26/2024 Minimum Data Set assessment documented the resident was cognitively intact, required moderate assistance of one staff for bathing and toileting, and did not refuse care. The 2/26/2024 comprehensive care plan documented a potential alteration in skin integrity related to incontinence and the intervention was to identify potential causative factors and eliminate/resolve when possible. The following observations of Resident #414 were made: - on 4/15/2024 at 11:34 AM a large clear trash bag of dirty clothes was in the resident's private bathroom. The entire floor of the room was sticky. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/15/2024 at 1:13 PM the resident had stubble on their face and stated they would like to be shaved. Their hair was greasy, and they wanted a shower and stated, their shower day moved every week for staff convenience. They stated they had all their clothes in the bathroom, and they were dirty because there was no staff to wash them. - on 4/16/2024 at 8:28 AM there was a large overflowing clear bag of dirty clothes in the resident's private bathroom. At 3:31 PM there was a large overflowing clear bag of dirty clothing and a round white basket of dirty clothing in the bathroom. The floor of the entire room was sticky. At 3:36 PM the resident was in the hall wearing an orange t-shirt and a black hooded sweatshirt and had greasy hair and stubble on their face. They stated they did not refuse their shower yesterday. - on 4/17/2024 at 8:30 AM in bed wearing the same orange t-shirt and black hoodie from the prior day. There was a large clear trash bag full of clothes in the resident's private bathroom. The resident had greasy and uncombed hair and had stubble on their face. Their room smelled of urine. The resident stated they were not sure of their shower day, but they wanted a shower. At 12:28 PM there was a brief with a brown smear on the floor in the resident's private bathroom next to an overflowing clear trash bag of laundry. The floor was sticky, and urine was smelled outside the room prior to entering. There was urine and feces in the toilet. - on 4/18/2024 at 8:26 AM the resident had greasy hair and stubble on their face in the dining room and was wearing a green sweatshirt and black pants. They stated they did not get a shower and would like one. At 8:44 AM registered nurse Educator #68 observed urine and feces in the resident's private bathroom. They stated they were not sure why the toilet was not flushed, and the resident might be independent. They stated not flushing the toilet was not dignified. During an interview on 4/18/2024 at 9:16 AM Resident #414's family member stated the family visited the resident several days a week on different days. They had observed a back up of laundry in the resident's bathroom. They brought in additional clothing on several occasions so the resident could wear clean clothes. They stated the resident liked to be clean and well groomed. The resident complained they did not get a haircut and wanted one. The family put extra money in the resident's account so the resident would never have to go without a haircut. During an interview on 4/18/2024 at 10:37 AM certified nurse aide #8 stated they were always assigned to Resident #414 and had never heard them refuse care, The resident's assigned shower was on Monday evening shift. They stated if a resident did not get a shower, they would be dirty and not feel good about themselves. Residents felt better after a shower. They stated laundry came to the unit twice a week on Tuesday and Thursday. Because clothing was backed up for residents, they sometimes had to wash residents' clothes themselves. They were going to wash Resident #414 clothes yesterday because they were overflowing and had run out of pants, however they did not have time to wash the dirty clothing. They saw the resident in the same clothes for two days and that was not dignified. They noticed a smell of urine in Resident #414's room and believed it came from another resident dumping urine in Resident #414 room and they notified the Unit Manager. During an interview on 4/18/2024 at 11:29 AM licensed practical nurse Unit Manager #4 stated laundry was picked up every Tuesday and it was brought back by laundry, but they were unsure of the timeframe. They stated laundry staff had a hard time keeping up and sometimes laundry was off the unit for more than four days. If laundry is piled up in a room, it could lead to odors. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/22/2024 at 9:01 AM the 5th floor had one blue cart of linen that was full, and staff brought up another blue cart as 10 additional bags of linen were on the ground next to the blue cart. Laundry worker # 72 stated each floor had a specific day when laundry was picked up. They stated laundry gets backed up because some residents go through more clothing because they are incontinent of urine, and they are short staffed. During an interview on 4/23/2024 at 9:28 AM the Director of Nursing stated they expected laundry to be picked up on laundry day. If laundry was not picked up timely it could lead to odors and bugs. They stated it was not dignified to have laundry backed up in a resident's room or for a resident to have to smell feces or urine from dirty clothing. They stated it was their expectation that residents' personal care needs were met and failure to do so was a dignity concern. 10NYCRR 415.5(a)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48446 Based on observation, interview, and record review during the recertification survey conducted 4/15/2024-4/23/2023, the facility did not ensure the right to reside and receive services with reasonable accommodation of resident needs and preferences for 1 of 2 resident (Resident #31) reviewed. Specifically, Resident #31 was not able to use their bathroom sink to effectively perform activities of daily living. Findings include: The facility policy Quality of Life-Dignity dated 1/10/2023 documented each resident shall be cared for in a manner that promoted and enhanced their sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem, and were treated with dignity and respect at all times. Resident #31 was admitted to the facility with diagnoses including hemiplegia (paralysis on one side of the body) affecting the dominant side, kidney disease, and obesity. The 2/12/2024 Minimum Data Set assessment documented the resident was cognitively intact, had functional limitation in the upper and lower extremities on one side, and required substantial/maximum assistance with oral hygiene, toileting, showering, and dressing. The comprehensive care plan initiated 7/24/2023 documented a self-care deficit related to a stroke with right sided hemiparesis. Interventions included encourage participation in activities of daily living, provide assistance with oral care, and moderate assistance with personal hygiene. During an observation on 4/15/2024 at 10:44 AM Resident #31 was attempting to get into their bathroom using a wheelchair. The entrance to the bathroom was narrow and the resident had difficulty entering the bathroom using their wheelchair. Upon entering they were unable to turn on the cold water as the sink was tight against the wall, there was a handicap bar low on the wall by the cold water handle, they were paralyzed on the right and could not reach the cold water handle with their left hand. They stated when bathing the water was often too hot and they had to use hot water to brush their teeth. During an interview on 4/17/2024 at 10:39 AM licensed practical nurse #6 stated Resident #31 was recently moved to a new room. They did not understand why the resident was moved to a room where they could not use the cold water in the bathroom sink because they were paralyzed on the right. They notified the Unit Manager of their concerns. During an interview on 4/18/2024 at 10:37 AM certified nurse aide #8 stated Resident #31 was not able to use the cold water in their bathroom because they were paralyzed on the right side, the bathroom was too small, and the cold water was too tight to the right side of the wall. During an interview on 4/18/2024 at 11:55 AM licensed practical nurse Unit Manager #4 stated Resident #31 was paralyzed on the right side and was not able to turn on the cold water in their bathroom because the cold water was too close to the wall and the resident could not reach it with their left hand. The resident needed a bathroom where they could use both the hot and cold water. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2024 at 9:28 AM the Director of Nursing stated they expected all residents should use the bathroom if they were able and desired to use it. They expected all residents to have access to both hot and cold water for activities of daily living. During an interview on 4/23/2024 at 11:41 AM occupational therapist #84 stated Resident #31 had right sided hemiplegia and was evaluated on 4/15/2024. The resident's strength was 0/5 on the right so they would not be able to use the right side at all. They stated the resident was cognitively intact and might need accommodations if they said they were unable to use the sink on the cold water side for brushing their teeth. All residents should be able to use both the cold and hot water in their bathrooms. 10NYCRR 415.5(e)(1) 48632

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 48052 48632 49831 Based on observation, record review, and interview during the recertification survey conducted 4/15/2024-4/23/2024 the facility did not ensure resident rights to personal privacy and confidentiality of their personal and medical records for 8 of 8 residents (Residents #1, #10, #133, #158, #305, #323, #325, and #397) reviewed. Specifically, Residents #1, #10, #133, #158, #305, #323, #325, and #397 identifying and personal information was posted in a public area visible to others. Findings include: The undated facility policy, Identifying Protected Health Information documented the facility was committed to ensuring the privacy and security of individual health information. To support this commitment, the facility would ensure that the appropriate steps were taken to properly identify and secure individuals' protected health information as required. Any health information relating to the past, present, or future physical or mental health or condition of an individual or the provision of health care to an individual would be protected. During observations on 4/18/2024 at 10:33 AM and 4/19/2024 at 11:49 AM personal identifying information for Residents #1, #10, #305 and #325 was posted in a public area on the 4th floor. The identifying information included personal resident information (room number, first name, last name, lab information, primary payor, bed status, diet, diet and liquid texture, and aspiration risk and confirmation). The information was posted in the 4th floor dining area to the left of the microwave and was highlighted yellow. During observations in the 11th floor dining room on 4/15/2024 at 12:12 PM, 4/17/2024 at 8:49 AM, 4/18/2024 at 9:04 AM, 4/19/2024 at 8:58 AM, and 4/22/2024 at 8:50 AM personal identifying information for Residents #158 and #397 was posted in the 11th floor dining room. The information was in a glass case and on a pillar in the middle of the dining room in a public area. The identifying information included personal resident information (the resident room number, the first name, last name, ordered diet including diet and liquid texture with aspiration risks highlighted, and special diet instructions). During observations on 4/16/2024 at 9:20 AM, 4/17/2024 at 8:59 AM, 4/19/2024 at 9:03 AM, and 4/22/2024 at 9:07 AM personal identifying information for Residents #133 and #323 was posted in a public area on the 13th floor next to the fireplace diagonal from the kitchen area. The identifying information included personal resident information (the resident room number, first and last name, and aspiration precautions). (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2024 at 10:46 AM, registered nurse Unit Manager #27 stated the posted resident information was a violation of resident's rights and the Health Insurance Portability and Accountability Act (a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge) as it divulged private information. They stated it was a facility policy to post the residents on aspiration precautions. They tried to make their unit posting as generic as possible so that there was not a lot of information with highlights. During an interview on 4/22/2024 at 3:18 PM, the Director of Social Work stated staff were educated about the Health Insurance Portability and Accountability Act annually and during orientation. They stated a resident listing that included a full name, diet order, diet texture, liquid consistency, and special instructions posted in a dining room without cover would be considered a Health Insurance Portability and Accountability Act or resident rights violation. During an interview on 4/22/2024 at 3:45 PM, the Director of Nursing stated staff were educated about resident privacy and rights when hired and during monthly meetings. They had a list of the residents, and they highlighted the residents who were on aspiration precautions. They stated they did not have the resident aspiration list covered before and it was posted on the pillar in the dining room for the certified nurse aides to review. The list should only contain resident name, highlighted in yellow with ASP for Aspiration precautions at the top of the list. During an interview on 4/23/2024 at 9:40 AM, the Director of Health Information stated a resident list with personal information, that was not covered and posted on a unit in full view of others was not appropriate. During an interview on 4/23/2024 at 12:07 PM, certified nurse aide/unit secretary #17 stated the Health Insurance Portability and Accountability Act meant staff should not disclose resident information to anyone unless it was to an individual identified in the chart as being allowed to have the information. They stated the aspiration risk sign should be covered because it was a violation of the residents' privacy. During an interview on 4/23/24 at 12:40 PM, registered nurse Unit Manager #16 stated in accordance with the Health Insurance Portability and Accountability Act they should not discuss resident information or leave resident information visible because other people could see the information. During an interview on 4/23/2024 at 12:55 PM, Assistant Director of Nursing #18 stated the Health Insurance Portability and Accountability Act protected residents' personal information. The residents on aspiration precaution list should be visible for staff only and the information should be covered to protect the residents' privacy. 10NYCRR 415.3(d)(1)(ii)

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	335136	A. Building B. Wing	04/23/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 Based on observation, record review, and interview during the recertification and abbreviated (NY00321560, NY00336003, NY00320334, NY00318518, NY00315691 and NY00330793) surveys conducted 4/15/2024-4/23/2024, the facility did not ensure residents had the right to a safe, clean, comfortable, and homelike environment for 6 of 14 resident units ([NAME] Units 3, 4, 8, 10, 11, and 13) reviewed. Specifically: - on [NAME] Unit 3, room [ROOM NUMBER]-W had overflowing laundry bags, the bathroom was visibly dirty and had a strong urine odor, and the room floors were sticky. - on [NAME] Unit 4, room [ROOM NUMBER]-W's alternating pressure mattress machine had a missing right hook to secure the machine, and a ceiling tile was missing. - [NAME] Unit 11 had sticky floors; room [ROOM NUMBER]-W had a dirty wall, and liquid and debris on the floor; and room [ROOM NUMBER]-W had a broken stone windowsill. - [NAME] Unit 8's and 13's common area ice and water machine had white dried matter along the grate/catcher plate, the table, the bottom of the shelf it was on, the floor underneath the machine, and the wall to the side of the machine. - [NAME] Units 4 and 10 had fruit flies. Findings include: The undated facility policy, Cleaning and Disinfection/Non-critical care and shared equipment documented the facility would ensure that the appropriate infection prevention and control measures were taken to provide a safe, sanitary, and comfortable environment to prevent the spread of infection in accordance with State and Federal Regulations. Resident rooms were cleaned and disinfected in accordance with environmental services policies and procedures. The undated facility policy, Safe & Homelike Environment documented the facility provided a homelike environment for those that resided in the facility. The residents had a right to a safe, clean, and comfortable environment. The facility provided residents with furnishings that met individual's desires, the layout of the facility did not pose a safety risk to residents and facilitated resident independence, and the facility ensured residents received necessary care and services. The facility policy, Pest Control Program revised 10/5/2017, documented the facility established an effective pest control program that assured the facility would be pest and rodent free. The facility was professionally inspected weekly and monthly based on observations or findings, and treatments would be scheduled. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated facility policy, Work Order System documented the facility utilized an electronic workorder system that was accessible to all staff to submit identified items that needed repairs, areas of concern, and pest control. The following observations and interviews were made on [NAME] Unit 3: - On 4/15/2024 at 11:34 AM, room [ROOM NUMBER]-W had a large clear trash bag of dirty clothes in the private bathroom and the floor of the room was sticky. At 1:19 PM, the resident stated they had a bag of clothes in the bathroom but there was no staff to wash them. - On 4/16/2024 at 8:28 AM and 3:31 PM, there was a large overflowing clear bag of dirty clothes in room [ROOM NUMBER]-W's private bathroom. The room's floor was sticky. - On 4/17/2024 at 8:30 AM, there was a large clear trash bag full of clothes in room [ROOM NUMBER]-W's private bathroom. At 12:28 PM, there was a brief with a brown smear on the floor in room [ROOM NUMBER]-W's private bathroom next to an overflowing clear trash bag of laundry. The floor was sticky and there was a urine odor in the room noticeable from the hallway. There was urine and feces observed in the unflushed toilet. - On 4/17/2024 at 8:37 AM, the resident in room [ROOM NUMBER]-W stated the certified nurse aide came into their room last night and left the dirty linen on the floor and it smelled. They stated it had been picked up by the certified nurse aide that did their morning care. At 9:40 AM, certified nurse aide #5 stated dirty linen was left on the floor from the night shift in room [ROOM NUMBER]-W which was not dignified and could be a potential infection or fall risk. During an interview on 4/18/2024 at 10:37 AM certified nurse aide #8 stated laundry came to the unit twice a week on Tuesday and Thursday. They stated because clothing was backed up for residents, they sometimes had to wash resident clothes themselves. They stated they were going to washroom [ROOM NUMBER]-W's clothes yesterday because they were overflowing and had run out of pants, however they did not have time to wash the dirty clothing. They stated they had seen residents in the same clothes for two days and that was not dignified. They have noticed a smell of urine in the room and believed it came from another resident dumping urine in room [ROOM NUMBER]-W. During an interview on 4/18/2024 at 11:29 AM licensed practical nurse Unit Manager #4 stated laundry was picked up every Tuesday and it was brought back by laundry, but they were unsure of the timeframe. They stated laundry staff had a hard time keeping staff, and sometimes laundry was off the unit for more than four days. If laundry is piled up in a room, it could lead to odors. During an observation and interview on 4/22/2024 at 9:01 AM [NAME] Unit 5 had one blue cart of linen that was full and there were 10 additional bags of linen on the ground next to the blue cart. Laundry worker # 72 stated each floor had a specific day when laundry was picked up. They stated laundry backed up because some residents go through more clothing due to incontinence, and they were also short staffed. During an interview on 4/23/2024 at 9:28 AM the Director of Nursing stated they expected laundry to be picked up on laundry day. If laundry was not picked up timely it could lead to odors and bugs. They stated it was not dignified to have laundry backed up in a resident's room or for a resident to smell feces or urine from dirty clothing. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following observations were made on [NAME] Unit 4: - On 4/15/2024, 4/16/2024, and 4/17/2024, room [ROOM NUMBER]-W's alternating air mattress machine was unsecured on the right side due a missing hook. - On 4/16/2024 at 10:10 AM, room [ROOM NUMBER]-W had a ceiling tile that was lifted and turned, and not secured in the ceiling support holder. - On 4/19/2024 at 9:20 AM, room [ROOM NUMBER]-W was missing a ceiling tile, the pieces were resting on the floor leaned against the heater. During an interview on 4/22/2024 at 3:57 PM, registered nurse Unit Manager #16 stated they put in a work request for the ceiling tile in room [ROOM NUMBER]-W a couple weeks ago as critical. When they tried to adjust the tile back into place on 4/19/2024, it broke completely in half and fell to the floor. During an interview on 4/23/2024 at 12:24 PM, housekeeper #62 stated they were responsible for cleaning resident rooms. They swept, dusted, removed trash, and mopped every room as needed. They did not recall any missing or broken ceiling tiles in room [ROOM NUMBER]-W. They would report any broken items to the Unit Manager or unit secretary and a work order would be filed. They would also add it to their own paperwork as the Housekeeping Manager would review it. The following observations were made on [NAME] Unit 11: - On 4/15/24 at 11:12 AM, resident room [ROOM NUMBER] had a whole section of stone windowsill next to the stationary armchair lifted and broken. There was a slightly jagged edge and a large gap underneath the stone windowsill from where it was lifted. - On 4/15/2024 at 10:27 AM, resident room [ROOM NUMBER] had a bed against the wall with brown matter smeared on the wall. - On 4/16/2024 at 10:50 AM, resident room [ROOM NUMBER] had a brown liquid drip mark on the wall behind the headboard of the resident's bed. - On 4/17/2024 at 8:51 AM, 9:59 AM, and 3:35 PM resident room [ROOM NUMBER] had a urine odor. There was a brown dried liquid drip mark on the wall behind the headboard. - On 4/18/2024 at 9:03 AM, the floors were sticky all around the 11th floor dining area. At 9:10 AM, the floors from common TV area down to room [ROOM NUMBER] were sticky. At 11:40 AM, the floor on the side of dining room between the counter and sink combination and round table was sticky. At 11:43 AM, the floor in front of the elevators was sticky. - On 4/19/2024 at 1:21 PM, resident room [ROOM NUMBER] had a large clear liquid puddle in the center of the room on the floor. - On 4/19/2024 at 9:39 AM, the floor to the left of the elevators was sticky. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 4/16/2024 at 10:53 AM, certified nurse aide #80 stated if they found something broken in a resident room or there was a maintenance issue, they put a work order into their electronic communications system for maintenance. They stated they were unaware of the broken windowsill in resident room [ROOM NUMBER]. During an interview and observation on 4/16/2024 at 10:55 AM, certified nurse aide #70 stated they were assigned to resident room [ROOM NUMBER] that day and was unaware of a broken windowsill. During an interview on 4/23/2024 at 10:13 AM, housekeeper #81 stated if there was a spill or debris on a resident's floor, all staff were responsible for cleaning it. They stated if staff saw something, they were expected to clean it up and not wait on housekeeping. If there was a smear or liquid on a resident's wall whoever saw it was responsible for cleaning it. During an interview on 4/23/2024 at 10:18 AM, licensed practical nurse Unit Manager #82 stated they expected both housekeeping and nursing to clean any messes they saw on the floor. Whoever saw it first should clean it. They stated if there was a smear on a wall, whoever found it should clean it. However, if it is obviously a resident's bowel movement, the certified nurse aides were to clean it and then housekeeping followed through. Pest Control: The following observations were made: - On 4/15/2024 at 12:12 PM, there was a fruit fly in the dining room during the lunch meal [NAME] unit 10. - On 4/23/2024 at 10:06 AM, there were fruit flies in room [ROOM NUMBER]-W on [NAME] Unit 4. Resident use equipment cleanliness: The following observations were made of water/ice machines on resident units: - On 4/15/2024 at 10:10 AM on [NAME] Unit 8, the dining area water/ice machine had a dried white substance around the base of the machine, along the table, on the bottom of the shelf, on the floor underneath the machine, and the wall to the side of the machine. - On 4/15/2024 at 11:39 AM on [NAME] 13, there was an active leak beneath the ice machine with two catch basins full of water. - On 4/16/2024 at 9:03 AM on [NAME] Unit 13, the ice/water machine had white dried matter under and around the leg of the ice machine, and along the grate catcher plate in the bottom of the ice machine. At 9:05 AM, the red wall outlet plate the ice machine was plugged into was splattered with white matter. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/17/2024 at 9:07 AM, on [NAME] Unit 13 there was a sticker on the water/ice machine documenting it was cleaned and sanitized on 1/31/2024. There was white build up on the catch grate and plate and discoloration splatter on the metal back plate under the ice nozzle. The counter under the machine had white build up. The red wall outlet plate the ice machine was plugged into, was splattered with white matter. During an interview on 4/15/2024 at 11:48 AM Maintenance worker #83 stated they cleaned the ice machines last week. 10 NYCRR 415.29(j)(1) 48446 48632

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48052 Based on record review, observation, and interviews during the recertification survey conducted 4/15/2024-4/23/2024, the facility did not ensure information on filing grievances was available for 11 of 11 anonymous residents present at the Resident Council meeting. Specifically, 11 anonymous residents present at the Resident Council meeting stated they did not know how to file an anonymous grievance. Findings include: The facility policy, Complaint Management Policy dated 2/21/2022 documented all residents would be informed at admission of their right to file a grievance and the information would be posted throughout the facility. Complaints could be filed either in written or in oral format to any staff member. The Director of Nursing served as the grievance official. During a Resident Council Meeting on 4/15/24 at 2:04 PM, eleven anonymous residents stated they were unaware of who the facility grievance officer was. They were told they had to report their concerns to their social worker. They stated they did not always receive follow up on grievances expressed and did not feel they could express concerns. The 11 anonymous residents were unaware they could file a grievance anonymously. During an observation on 4/17/2024 at 9:03 AM, a sign on the 13th floor documented to address any grievances, concerns, or unresolved issues firstly to the Unit Manager or Social Worker, secondly to the grievance officer, who was the Director of Nursing, or thirdly to the Ombudsman. Next to the sign was the number for the New York State Complaint hotline labeled Patient Care Hotline and the New York State Ombudsman poster. The compliance officer contact information was not documented. During an interview on 4/22/24 3:45 PM, the Director of Nursing stated a family member or resident could call them or write an email or letter to report a concern and they would follow up based on the information provided. They stated every grievance they received was written on the grievance log unless it was about a resident who stated they did not receive care, that would be an incident report, not a grievance. They stated grievances included concerns about discharge, the financial department, or missing items. They stated a resident filed an anonymous grievance by contacting them directly or having the social worker contact them. An anonymous grievance could be filed by giving a letter to security to put in their mailbox, sliding it under their office door, or by contacting the Ombudsman. They were aware it was a resident's right to file a grievance anonymously. During an interview on 4/22/24 at 5:01 PM, the Director of Social Work stated the Director of Nursing was the grievance officer. They stated a resident filed a grievance and the staff utilized their grievance form and then turned it into the Director of Nursing. They were unaware of a process in the facility for residents to file an anonymous grievance. They were aware it was a resident right to be able to file an anonymous grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/24 at 11:05 AM, the Administrator stated the residents or family could submit anonymous grievances through the compliance officer or through the Ombudsman. They stated they believed the compliance officer number was in the resident handbook. If a resident wanted to remain anonymous, the resident could contact them directly or contact the compliance officer. 10NYCRR 415.3(C)(1)(ii)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). 48446 Based on observation, interview, and record review during the recertification survey conducted 4/15/2024-4/23/2024, the facility did not ensure residents were free from involuntary seclusion for 1 of 1 resident (Resident #429) reviewed. Specifically, Resident #429 reported feelings of social isolation when they were not allowed to leave their room to attend activities, have meals in the dining room, or socialize with peers and family because their portable oxygen tank was empty and was not refilled. Findings include: The facility policy Resident Abuse Reporting dated 8/1/2023 documented the facility to prohibited mistreatment, neglect, or abuse. The facility would not tolerate or permit verbal, mental, sexual, or physical abuse including involuntary seclusion of residents. Involuntary seclusion was defined as separation of a resident from other residents in their room against the residents will or the will of the legal representative. The facility policy Portable Liquid Oxygen System dated 10/10/2029 documented the oxygen cylinders must be filled from the stationary reservoir when empty. The certified nurse aide was responsible for monitoring the delivery of oxygen therapy and filling portable cylinders from the base unit. Resident #429 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (lung disease) and respiratory failure with hypoxia (low oxygen in tissues). The 1/24/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not reject care, felt it was somewhat important to do things with groups of people, required supervision with transfers, required oxygen, was short of breath or had trouble breathing when at rest, with exertion, and when lying flat. The 4/11/2023 physician order documented oxygen 4 to 6 liters via nasal cannula to maintain oxygen saturations of 90% or greater. The comprehensive care plan and the resident care instructions dated 4/23/2024 documented the resident was alert and oriented and required oxygen 4-6 liters via nasal cannula to maintain oxygen levels of 90% or greater. The resident had an alteration in respiratory status related to chronic obstructive pulmonary disease and respiratory failure with hypoxia. Interventions included oxygen at 4-6 liters to maintain oxygen levels over 90%, may use concentrator out of room, and pace and schedule activities providing adequate rest periods. The resident wished to participate in therapeutic activities including group programs, self-directed leisure, 1:1 programming, and special events. The activity attendance record documented Resident #429 attended 21 activities in 2/2024, 37 activities in 3/2024, and 18 activities in 4/2024. Activity categories included group activities, individual engagement, and independent activities all occurring after 11:00 AM. The following observations were made: (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/15/2024 at 12:40 PM, the resident was in the dining room at a table with four residents with a portable oxygen tank on the back of their wheelchair set at 5 liters and flowing through a nasal cannula. - on 4/16/2024 at 3:21 PM, the resident was participating in an activity in the common area. - on 4/17/2024 at 8:37 AM the resident was in bed wearing oxygen piped through the wall at 5 liters. The portable oxygen tank on the back of the wheelchair was empty. The resident stated the oxygen tank was empty at 8:00 PM the previous evening and they switched themselves from the portable oxygen tank to the wall oxygen. They stated no one replaced the oxygen tank overnight so they had to stay hooked to the wall oxygen until staff brought a portable tank that had oxygen in it. - on 4/17/2024 at 8:43 AM seven empty oxygen tanks were in a blue cart at the nursing station. There was one full tank. - on 4/17/2024 at 10:00 AM several residents were observed in the activities area listening to music. Resident #429 was not in attendance. - on 4/17/2024 at 10:04 AM the resident was in their room and stated they would like to attend activities in the morning and were not able to because there was never any portable oxygen. They stated certified nurse aides were supposed to fill the portable tanks every shift and they did not. They stated they were told by staff it was on the assignment sheet to complete this task every shift. Staff reported they did not want to fill the portable oxygen tanks because they had to leave the unit and put on a gown to fill the tanks. The resident stated they enjoyed activities and were not able to attend any morning activities because there were no filled portable oxygen tanks most mornings. They would like to attend the morning activities. They stated it started to improve when licensed practical nurse Unit Manager #4 transferred to the unit, but they were back to not filling portable oxygen tanks. - on 4/18/2024 at 9:46 AM the resident was in their room in bed. They stated they did not have breakfast and staff did not get them up for the day. They stated they were very upset because they were going to miss their hair appointment that was scheduled for 9:30 AM. On 4/17/2024 after their visitor left, they went to the activity area to enjoy the activity in the afternoon. They ran out of oxygen and staff checked all the portable tanks in the blue cart and all of them were empty. They stated staff that was assigned on the day shift to fill the portable oxygen tanks started yelling and stated they did not want to fill the tanks. They did not know the name of the staff. One staff was able to locate a 1/2 full tank that lasted less than one hour. - on 4/22/2024 at 12:32 PM the resident was in the dining room eating at a table with their peers with their portable oxygen at 5 liters via a nasal cannula. They stated they were upset because they did not get up until 11:00 AM today and missed the morning activity. They stated they wanted to get up earlier in the morning so they could participate in activities and leave their room when they wanted. They stated they felt like they were isolated in their room because they did not have portable oxygen so they could go to activities and do other things like getting their hair done. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/2024 treatment administration record documented Resident #429 was to receive oxygen at 4 to 6 liters via nasal cannula to maintain oxygen saturations of 90% or greater every shift. Nurses were to check the oxygen tank every 2 hours when the resident was out of the room and not on wall oxygen to prevent the resident from running out of oxygen. The tank check included a key: F=full; R=replaced; and W=wall (oxygen received via wall unit). On 4/17/2024 the treatment administration record documented the W for the entire day; on 4/18/2024 the treatment administration record documented W from 12:00 AM-10:00 AM, F from 12:00 PM-2:00 PM, R at 2:00 PM, and F from 4:00PM-10:00 PM; on 4/22/2024 W from 12:00 AM-8:00 AM, R at 10:00 AM, F from 12:00 PM-2:00 PM, R at 2:00 PM, repla at 4:00 PM, and 6:00 PM. and W from 8:00 PM-12:00 AM. During an interview on 4/17/2024 at 9:40 AM certified nurse aide #5 stated the resident's unit used oxygen on the wall and if residents wanted to be out of their room, they required a portable oxygen tank. They stated the portable oxygen tanks were filled at the end of every shift by certified nurse aides. They had worked when there were no portable tanks available for residents who required oxygen. During an interview on 4/17/2024 at 10:39 AM licensed practical nurse #6 stated many residents on the unit required oxygen but were not sure exactly how many. The unit utilized wall oxygen and when residents wanted to leave their room, they required a portable oxygen tank. They stated they observed portable tanks running out on numerous occasions and when that happened residents were moved to their room to hook up to the wall, so they did not go without oxygen. They stated filling the portable oxygen tanks was assigned on the daily assignment sheet, however, was not always competed because of short staffing. During an interview on 4/17/2024 at 11:18 AM certified nurse aide #7 stated they worked the overnight shift. They were assigned to fill the portable oxygen tanks as it was written on the assignment sheet. They believed they filled the portable oxygen tanks that morning but could not be sure. They stated when they filled portable oxygen tanks, they did not pick up empty tanks from residents' rooms and only filled the tanks in the blue cart. They stated it was important to fill the portable oxygen tanks because residents needed oxygen to breath and could not leave their room if the tanks were empty. During an interview on 4/18/2024 at 10:37 AM certified nurse aide #8 stated portable oxygen tanks were filled every shift by certified nurse aides and were filled in the first floor (basement) oxygen room. Residents on oxygen required oxygen to breathe and Resident #429 was on oxygen. They stated there had been numerous occasions when the portable oxygen tanks were not filled. When there were no portable tanks, the resident was confined to their room and hooked up to wall oxygen until staff was able to go to the oxygen room and fill up empty portable oxygen tanks. If a resident was hooked to wall oxygen they would miss out on activities, appointments, and more. During an interview on 4/18/2024 at 11:04 AM recreation therapist #9 stated they planned and lead two activities on the unit daily, one in the morning and one in the afternoon. They stated Resident #429 attended, participated in, and enjoyed activities. They stated the resident only attended afternoon activities and they did not know why the resident did not attend activities in the morning. They stated Resident #429 left the afternoon activity the prior day because they ran out of oxygen. The resident went to the nursing station to notify staff they needed oxygen. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/2024 at 11:55 AM licensed practical nurse Unit Manager #4 stated on this unit oxygen was on the wall and if a resident wanted to leave their room, they required a portable oxygen tank. They stated they noticed portable oxygen tanks were empty when they started on the unit and saw improvement as it is assigned to a certified nurse aide on every shift. When tanks were not filled residents were not able to leave their room which was restrictive. During an interview on 4/23/2024 at 9:28 AM the Director of Nursing stated units 3C and 4C had piped in oxygen and if a resident on oxygen wanted to leave their room, they needed a portable oxygen tank. Certified nurse aides were responsible for filling the tanks and hooking the resident to the oxygen. Nurses checked the amount of the required oxygen to make sure it was accurate for each resident. The certified nurse aide responsible for filling the tanks was listed on the daily assignment sheet. They stated all staff was trained on filling the portable tanks with oxygen. They expected portable oxygen tanks to be filled by staff every shift, every day, and did not expect that residents would be secluded to their room because there was no portable oxygen. If a resident wanted to leave their room and could not that was considered isolation. 10 NYCRR 415.4

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48446 48895 Based on observation, record review, and interview during the recertification and abbreviated (NY00315691, NY00318518, NY00320334, NY00321560, NY00329469, NY00330471, NY00331762, and NY00332641) surveys conducted 4/15/2024 through 4/23/2024, the facility did not develop and implement a comprehensive person-centered care plan to meet the residents medical and nursing needs for 3 of 4 residents (Residents #62, #150 and #201) reviewed. Specifically, Resident #201 did not have a comprehensive care plan developed to include outside privileges or smoking outside on facility grounds; Resident #62 did not have a positioning pillow, palm guard, or pressure reduction boots as planned; and Resident #150 was not wearing their pressure reducing heel boots as planned. Findings include: The 8/8/2022 facility policy Comprehensive Care Planning, documented the facility must develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs. The services were to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The 4/19/2023 facility policy Smoking Policy, documented the facility was tobacco free. Any form of smoking, including but not limited to e-cigarettes, vaping, and all other uses of tobacco and marijuana products were prohibited on all facility properties. Facility properties included all land, building, structures, parking lots, and means of transportation owned by the facility. No one could smoke along any pathway or walkway leading to or from the parking area, nor at the picnic tables on any of the grassy areas or the parking lots. The 10/2023 facility policy Off Unit/Leave of Absence, documented that the facility would provide residents opportunities to leave the unit that provides safe and appropriate experiences for interacting outside. The attending physician/designee would provide an order for Leave of Absence and would evaluate the order on a minimum of every 30, 60, or 90 days. The order may be completed from the standing order in the medical record. The purpose of the policy was to be aware when a resident was off the unit and their location within or outside the facility. Residents must notify nursing on the unit and sign out and back in on the Resident Sign-Out book. The facility policy Skin and Wound - Pressure Injury Prevention, Identification, Treatment and Documentation of Pressure Injury dated 8/17/2022 documented each resident received treatment and services to promote healing and prevent new pressure injuries from developing. Use heel offloading devices such as pressure reducing boots or heel lifts on heels for protection. The most important function in management of pressure damage was pressure relief. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Resident #201 had diagnoses including nicotine dependence, noncompliance with other medical treatment and regimen due to unspecified reason and need for assistance with personal care. The 3/13/2024 Minimum Data Set assessment documented the resident was cognitively intact, had limited range of motion in both upper and lower extremities on both sides, and was independent with wheelchair use, The comprehensive care plan initiated on 8/2/2021 documented the resident had potential for alteration in mood state related to anxiety, depression, and history of nicotine dependence. Interventions included one on one visits as needed, allow time to express feelings as needed, behavior health referrals as needed, provided emotional support to the resident as needed, provider evaluation and/or re-evaluation of psychotropic medications, observe for desired and undesirable effects, reduce environmental stimuli, respect wishes for privacy, and validate feelings. The care plan did not include resident centered interventions for nicotine dependence. The 11/24/2023 incident note by registered nurse Unit Manager #28 documented Resident #201 was observed outside in a wheelchair smoking a cigarette. When questioned about smoking they stated they needed to smoke because the place drove them crazy. The 11/24/2023 social work note by social worker #60 documented a room search was conducted and 4 empty boxes of cigarettes and one lighter were found. The resident turned over the light and boxes were thrown away. There were no documented interventions added to Resident #201's care plan based on the smoking incident in November 2023. During an observation and interview on 4/16/2024 at 8:17 AM, Resident #201 was sitting in their wheelchair in the driving lane of the back parking lot between the visitor and employee lots. The resident stated they enjoyed the sunshine. During an observation on 4/18/2024 at 6:45 PM, Resident #201 attempted to smoke outside, concealed their cigarette, and remained under the awning of the building for several minutes. During an interview on 4/19/2024 at 11:26 AM, certified nurse aide #77 stated Resident #201 usually let the nursing staff know when they were leaving the floor. They left the floor to go downstairs and outside to smoke. The resident was usually in between the 2 front doors or the covered patio next to the employee parking lot. They sat down there and would ask anyone they saw for cigarettes or assistance with lighting a cigarette. The resident had a few other friends that did the same thing. Certified nurse aide #77 stated they had not seen the resident with a lighter but had seen them smoking outside. An electronic communication from the Administrator dated 4/20/2024 at 2:11 PM documented Resident #201 did not have any out of pass assessments or smoking assessments. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2024 at 11:13 AM, registered nurse Unit Manager #28 stated that if the resident was not on the unit, they would go downstairs to find them. The resident was good about telling staff when they were leaving the unit. The resident would not explain where they were going, only that they would return for the next mealtime. The resident did not have an off the unit assessment and therapy listed them as independent with a wheelchair. If there was an emergency in the building, they would call the front desk security to see if they could see the resident. Resident #201 was caught smoking back in November. The current care plan just states a history of smoking. The Minimum Data Set assessment nurse was responsible for quarterly updates and reviews of the care plan, but registered nurse Unit Manager #28 was responsible for updates on episodic issues. An electronic communication from the Administrator dated 4/22/2024 at 11:14 AM, documented Resident #201 did not have any sign-out sheets for leaving the unit from 10/1/2023- 4/22/2024. During an interview on 4/22/2024 at 3:55 PM, Assistant Director of Nursing #23 stated that if a resident was off the unit the floor staff would have to account for them in the event of an emergency. If the resident was outside, they would have to be alert and oriented. There was no specific assessment for whether a resident could be outside. Resident #201 was appropriate to go outside unsupervised. The resident was not a risk to wander or elope. They were aware the resident was a smoker, but the grounds were non-smoking, and the resident was educated. The resident could use their cell phone if they needed assistance when they were off the unit. During an interview on 4/22/2024 4:43 PM, the Administrator stated that if a resident was caught smoking a full investigation should have been completed and interventions added to the resident's care plan and care card based on the findings of the investigation. Residents could leave the facility if they were alert and oriented but should not be in parking lots. If a resident was found in a parking lot staff should intervene. Interventions should be added for safety. There was no assessment to determine ability to go outside. The facility was responsible for keeping the resident safe even when they were outside. Resident #201 was not an elopement risk, if they said they were going outside, they would come back. The resident would communicate via cell phone. During an interview on 4/23/2024 at 1:27 PM, the Director of Nursing stated that creating person-centered care plans was a project. They used to do them on paper and were trying to make them personalized. The Director of Nursing would check to see if an elopement assessment was done for a resident if there was concern, but they checked for completeness, not accuracy. There were no smoking audits as they were a smoke free facility. The expectation was that the resident would have a care plan for the smoking habit. If the resident was caught smoking 3-4 times, they would get a wander alert device. 2) Resident #62 was admitted to the facility with diagnoses including stroke with hemiplegia (one sided weakness), obesity, and chronic obstructive pulmonary disease (chronic lung disease). The 1/25/2024 Minimum Data Set assessment documented the resident was cognitively intact, required extensive of assistance of two for most activities of daily living, was non-ambulatory, and had functional limitation in range of motion in all 4 extremities. The comprehensive care plan initiated 6/3/2021 documented the resident had activities of daily living self-care performance deficits related to limited mobility. Interventions included for left hand contracture, palm guard with roll at all times, resident was allowed to remove the palm guard during the day for a break. (continued on next page)

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	04/23/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan initiated 8/12/2022 documented the resident had potential for skin impairment related to fragile skin, complex medical conditions, and the resident preferred to lie on their back while in bed. due to immobility. Interventions included the resident was to wear pressure reduction booties when in bed, a bariatric (referring to obesity) wound surface mattress with positioning pillows to protect skin. The following observations of Resident #62 were made: - on 4/17/2024 at 1:26 PM in bed without pressure reduction booties on their feet. The booties were not observed in the room. Resident #62 stated the pressure reduction booties were removed from their room several months ago and had not been replaced. The resident stated the pressure reduction booties made them more comfortable because they were always in bed. - on 4/18/2024 at 12:24 PM and 3:44 PM in bed. There were no pressure reduction booties on their feet, no positioning pillow, and no left palm guard. - on 4/19/2024 at 8:31 AM in bed without pressure reduction booties on their feet or a positioning pillow. - on 4/19/2024 in bed without pressure reduction booties on their feet or a positioning pillow. During an interview on 4/18/2024 at 3:46 PM certified nurse aide #19 stated they used the care plan to know resident specific care instructions and they were individualized for each resident. They stated Resident #62 was not care planned for pressure reduction booties. If a resident was care planned for p booties and did not have them, they could have skin breakdown on their heels. During an interview on 4/18/2024 at 4:17 PM licensed practical nurse #12 stated residents received individualized care based on their care plan. Failure to follow the care plan could impact resident outcomes. They believed Resident #62 was care planned for positioning pillows as they leaned to the right and looked like they might fall off the bed. During an interview on 4/19/2024 at 9:12 AM certified nurse aide #10 stated Resident #62 should wear a palm guard in their left hand because they had a contracture. They stated failure to wear the palm guard could increase the contracture. They stated the resident always leaned to the right like they are going to fall out of bed because they could not use their left side. They bought the resident a neck pillow to help with positioning, but they had never seen a positioning pillow. They did not believe the neck pillow, or the positioning pillow was on the care plan. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/19/2024 at 10:57 registered nurse Unit Manager #14 stated residents' care plans were individualized and drove the care card which is what the certified nurse aides used to know what care was necessary for each resident. They stated most residents on their unit were transferred from the rehabilitation unit and the care plan was initiated there. They stated they updated the care plan when the physician, therapy, or other discipline had recommendations for the residents. They stated pressure reduction booties were used to offset pressure to prevent skin breakdown on the heels. A positioning pillow was used to change a resident's position to prevent skin breakdown. If a resident was ordered to have pressure reduction booties or a positioning pillow and they did not, they could develop wounds, be uncomfortable, have pain, and increase the potential for infection. If a resident refused the booties or pillow it would be documented in a progress note. There was no documentation stating the resident refused either the booties or the positioning pillow. They stated they expected the items to be in the room if they were recommended. During an interview on 4/19/2024 at 12:15 PM physical therapist #15 stated that positioning devices were assessed for safety by therapy with the individual resident. They stated a risk benefit analysis had to be done prior to implementing that intervention to make sure the positioning device was safe and not being used as a restraint. They stated Resident #62's positioning pillow was not a therapy recommendation but a nursing intervention. 3) Resident #150 had diagnoses including diabetes, failure to thrive, and stroke. The 2/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required substantial assistance for hygiene, dressing, bed mobility, and transfers, was at risk for developing pressure ulcers/injuries, did not have pressure ulcers/injuries, and had pressure reducing devices for the chair and bed. The comprehensive care plan initiated on 1/29/2024 documented the resident had an activities of daily living deficit related to decreased mobility. Interventions moderate assistance of 1 when rolling left and right, the resident must wear pressure reducing boots as resident is supine (lying on back) in bed; bed to chair transfer dependent on 2 with mechanical lift, pressure reducing boots on when in wheelchair. The resident had potential for alteration in skin integrity related to decreased mobility and non-ambulatory. Interventions included elevate/float heels with pillows while in bed. A physician order dated 2/3/2024 documented to apply LNard boots (used for pressure reduction and/or foot stabilization) in the AM when out of bed and remove at night. The care instructions active as of 4/22/2024 documented to bilateral lower extremities apply LNard boots in AM when out of bed and remove at night. Pressure reducing boots on when in wheelchair and elevate/float heels with pillows while in bed. The resident was observed out of bed in their wheelchair without pressure relieving boots or LNard boots: - on 4/16/2024 at 8:26 AM in the dining room wearing blue nonskid socks and their feet were resting on the footrest of their wheelchair. - on 4/22/2024 at 12:12 PM in the dining room wearing blue nonskid socks and their feet were resting on the footrest of their wheelchair. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 4/23/2024 at 10:19 PM in the common activities area wearing blue nonskid socks and their feet were resting on the footrest of their wheelchair. The 4/2024 Treatment Administration Record documented to bilateral lower extremities apply LNard boots in AM when out of bed and remove at night. The treatment administration record documented the LNard boots were in place at 8:00 AM on 4/16/2024 by licensed practical nurse #78 and on 4/22/2024 by licensed practical nurse #79. During an interview on 4/23/2024 at 10:44 AM, certified nurse aide #49 stated they would look in the Kardex for resident specific care instructions. They were responsible for the resident today and was not aware they required any special pressure prevention devices to their heels. They reviewed the Kardex care instructions on the computer and stated the resident should have had pressure reduction booties on or at least offered. During an interview on 4/23/2024 at 11:03 AM, certified nurse aide #8 stated the Kardex provided instructions for the individual resident needs. They stated the Kardex documented in the section of chair to bed transfer it showed that the resident required pressure reduction booties on when out of bed in their wheelchair. They did not think to look in that area. During an interview on 4/23/2024 at 11:23 AM, licensed practical nurse #50 stated the Kardex provided the directions for staff to be able to care for the residents. Residents were expected to have the splints or devices worn as ordered and directed. Nurses should sign for them in the treatment administration record. The LNard boots were to prevent skin breakdown. During an interview on 4/23/2024 at 11:34 AM, licensed practical nurse #48 stated the Kardex information was generated by the care plan, and they should match. The computer documented an order to wear LNard boots in AM and off when in bed every day. They needed them for risk of pressure, and they should have them on their feet. During an interview on 4/23/2024 at 11:45 AM, registered nurse Unit Manager #51 stated staff used the residents care plan to know how to provide care. The computer displayed the resident required LNard boots when out of bed and they expected them to be worn to prevent pressure. During an interview on 4/23/2024 at 12:55 PM, Assistant Director of Nursing #18 stated staff should use the Kardex or the care plan to care for each resident. The programs worked together, and the information should match. The ordered heel protectors should be applied unless the resident refused and then documented accordingly. 10NYCRR 415.11(c)(1)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 48446 Based on interview and record review during the recertification and abbreviated (NY00320334) surveys conducted 4/15/2024-4/23/2023, the facility did not ensure the discharge needs of each resident were identified and resulted in the development of a discharge plan for 1 of 1 resident (Resident #429) reviewed. Specifically, Resident #429 did not have an active discharge plan, expressed interest in a lateral transfer to local nursing facilities, and was not updated on the status of a lateral transfer request. Additionally, Resident #429 was not invited to participate in the development of a person-centered care plan. Findings include: The facility policy Discharge Planning, revised 1/30/2015, documented the interdisciplinary care planning team and social worker would collaborate with the resident/designated representative regularly and reviewed the resident's potential for discharge to establish a projected discharge date . The social worker arranged and facilitated the resident/designated representative discharge planning meeting to discuss rehabilitation progress, clinicals status/needs, discharge goal, and services required upon discharge and documented this in the medical record. The facility policy Comprehensive Care Planning dated 8/8/2022 documented the facility must develop and implement a comprehensive person-centered care plan for each resident and in consultation with the resident and the resident's representative. To the extent practicable, the participation of the resident and the resident's representative. An explanation must be included in a resident's medical record if the participation of the resident and their representative is determined not practicable for the development of the resident's care plan. Resident #429 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (lung disease), respiratory failure with hypoxia (low oxygen), and diabetes. The 1/24/2024 annual Minimum Data Set assessment documented the resident was cognitively intact, the resident and family participated in assessment and goal setting, the resident's overall goal for discharge was blank, and active discharge planning was already occurring for the resident to return to the community. The care area assessment summary did not trigger a return to community referral or a care planning decision. The 4/13/2023 Social Service History and Initial Assessment completed by social worker #29 documented the resident planned to return to the community, had potential barriers to discharge (barriers not specified), and required community services after discharge. The 4/25/2023 progress note by social worker #29 documented upon discharge Resident #429 was going to live with their child. The comprehensive care plan initiated 6/7/2023 documented the resident had a supportive family. Interventions included contact family for Interdisciplinary Care Meetings as needed and invite to care plan meetings as needed. The comprehensive care plan did not include discharge potential or plans. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/22/2023 progress note by social worker #29 documented Resident #429's family member requested a lateral transfer to two specific local long term care facilities. The 6/23/2023 progress note by social worker #29 documented one of the two local facilities where Resident #429 had requested a lateral transfer did not have an available bed at this time and the resident was placed on a waiting list. They would follow up at a later date. The 8/7/2023 Social Services Quarterly Note completed by social worker #29 documented the resident did not have any changes regarding their feelings about discharge potential. Comments related to discharge potential documented please see multi-disciplinary notes for updates. A Multidisciplinary Care Conference form documented a quarterly meeting was held on 8/8/2023. Lateral transfer requests were made to three local skilled nursing facilities and there were no openings. The attendees at the meeting did not include the resident or their family. A Multidisciplinary Care Conference form documented a quarterly meeting was held on 11/8/2023. There was no documentation of a discharge plan. The attendees at the meeting did not include the resident or their family. A Multidisciplinary Care Conference form documented a quarterly meeting was held on 2/7/2024. There was no documentation of a discharge plan. The attendees at the meeting did not include the resident or their family. There was no documented evidence of an active discharge plan and follow-up from 8/8/2023 through 2/7/2024. During an interview on 4/16/2024 at 11:26 AM Resident #429 stated they had been in the facility for one year and were never invited to a care plan meeting to discuss their discharge. During an interview on 4/22/2024 at 03:28 PM social worker #60 stated resident #429 was cognitively intact and had a care plan meeting scheduled for the following Friday. Care plan meetings were completed with the interdisciplinary team every quarter and both the resident, and the family were invited to the meetings. Residents' family could choose to attend in person or by phone. Both family and residents had the option to decline attendance except on the annual review. The resident or resident representative had to attend the annual meeting. They stated they were resident's social worker for approximately 7 months. They were not aware of the discharge plan for Resident #429. The resident had a referral sent to a local long term care facility back in June of 2023 and was placed on a waiting list. They stated they had not followed up on the status of the waiting list for this resident and they should have. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2024 at 4:19 PM the Director of Social Work stated care conferences were held with every resident on admission, quarterly, annually, and with any significant change and were completed to provide the best individualized care for the resident. Care conferences were in conjunction with nursing, recreation, and nutrition so all staff knew how to care for the residents. Care conferences included discharge planning and discharge planning was ongoing. They stated Resident #429's medical record documented the resident was interested in a lateral transfer to two local nursing homes. One referral was sent, and the resident was placed on a waiting list in June of 2023. There was no follow up after that referral and they expected follow up should have occurred between June 2023 and April 2024. It was not done because the social worker assigned to the resident was new. During an interview on 4/23/2024 at 8:18 AM Resident #429 stated they were supposed to have a care plan meeting last Friday and no one came to get them, so they did not know if it happened. They wanted to be discharged to two local long term care facilities when they were admitted but were told by the facility that because of insurance reasons they were no longer eligible for a transfer. 10NYCRR 415.11(d)(3)

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	335136	A. Building B. Wing	04/23/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 37516 48052 48446 48632 50561 Based on observation, record review, and interviews during the recertification and abbreviated surveys (NY00315691, NY00318518, NY00321560, NY00329469, NY00330555, NY00332641, NY00334153, NY00336003, and NY00338231) conducted 4/19/2024-4/23/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 10 of 13 residents (Residents #62, 117, 124, 133, 150, 215, 305, 325, 384, and 414) reviewed. Specifically: - Resident #62 had unkempt hair, excessive facial hair, and unkept fingernails; - Resident #117 had unkept fingernails; - Resident #124 had unkept fingernails, greasy hair, and excessive facial hair; - Resident #150 remained in bed due to mechanical lift battery issues and was poorly positioned for meals; - Resident #133 was poorly positioned in bed for breakfast meals; - Resident #215 was not toileted as planned and had excessive facial hair; - Resident #305 was not toileted for over 5 hours; - Resident #325 had greasy hair and was not toileted as planned; - Resident #384 did not receive a shower as planned; and - Resident #414 did not receive a shower as planned and had excessive facial hair. Findings include: The facility policy Resident Nail Care dated 8/8/2022 documented residents received fingernail and toenail care to prevent potential discomfort or injury. Any nursing staff was able to provide nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Aspiration Precautions and Standards of Care dated 11/1/2022 documented measures to prevent or lessen the risk of food, fluids, or other ingested material from entering the respiratory tract. Residents were to maintain an upright position throughout the meal and 30 minutes after. The facility policy Meal Service dated 11/1/2022 facility policy documented a staff member must be assigned to monitor the residents during the meal if there were residents that ate in their room and were not on aspiration precautions. The facility policy Quality of Life- Dignity dated 1/10/2023 documented each resident should be cared for in a manner that promoted and enhanced their sense of well-being, level of life satisfaction, feeling of self-worth and self-esteem. Examples were personal grooming such as hair styling, nails, and facial hair. The facility policy Activities of Daily Living (ADLs) dated 3/12/2024 documented the facility would provide the necessary care and services to ensure that a resident's abilities in activities of daily living did not diminish unless avoidable. Examples included hygiene, mobility, and dining. The resident who was unable to carry out activities of daily living would receive the necessary services to maintain grooming and personal hygiene. 1) Resident #133 had diagnoses including cerebral palsy (a condition affecting movement and posture), stroke affecting the left side with weakness, and gastroesophageal reflux disease. The 2/9/2024 annual Minimum Data Set assessment documented the resident was cognitively intact, had functional limitation impairment of both legs, required set up assistance for eating, maximum assistance for rolling left or right, was totally dependent for bed mobility, and received a therapeutic diet. The 12/22/2022 physician order documented the resident was on a no added salt, unmodified texture diet with thin liquids. The 2/26/2024 revised comprehensive care plan documented the resident had a hiatal hernia (the upper stomach bulges through the diaphragm), gastroesophageal reflux, had a stroke with left sided weakness, had cerebral palsy, and had activities of daily living deficits. Interventions included sit upright after meals, diet as ordered, monitor for difficulty swallowing, monitor for coughing/choking when lying down, speech therapy as needed, anticipate, and meet needs, moderate assistance of 1 from lying to sitting position, and maintain good body alignment. During an interview on 4/15/2024 at 1:47 PM Resident #133 stated staff told them they did not have time in the morning to pull the resident up in bed to eat breakfast properly and this was a frequent occurrence. Resident #133 was observed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 4/16/2024 at 9:06 AM, in bed with the head of the bed raised and a pillow behind their head. The resident had an over bed tray table in front of them and the height of the table was raised to the resident's mid face. The resident had to reach up to get the food off the tray. At 9:48 AM, the tray table remained raised to the resident's mid face, the resident was slouched in the bed, and their voice sounded gurgled. The resident cleared their throat and stated it was hard to eat their food that way. The resident reached up to get a banana after turning the tray so they could reach it due to the height of the table. - on 4/17/2024 at 9:22 AM, sliding down in the bed, almost chin to chest, with the head of the bed elevated. The over bed tray table had a meal tray on top and was positioned at chin level to the resident. The resident reached up and pulled a banana and small container of eggs down to their chest to eat. The resident coughed while talking. The resident's voice sounded gurgled. The resident stated staff did not have time that morning to pull them up in bed. - on 4/18/2024 at 9:15 AM, lying in bed with the head of bed raised. The over bed tray table was chin height. The resident had to reach up to retrieve food items from the tray. At 12:27 PM, the resident stated they would prefer to get out of bed for breakfast, but staff had told them multiple times in the past they did not have time. The family was in the room and stated the resident did not like to eat in bed and it was not safe for the resident to eat while lying in bed. The resident agreed they did not like to eat in bed and felt it was not safe. - on 4/19/2024 at 9:21 AM, lying in bed in a slumped posture. The tray table had a meal tray on the top and was at nose height of the resident. The resident reached up and pulled down a small plate of eggs, they placed the plate on their chest, so they did not have to reach up for each bite. - on 4/22/2024 at 9:04 AM slouched in bed eating breakfast. The head of the bed was raised, and the tray table was level with their chin. The resident had to raise their arm to reach food with their fork and move the fork down to their mouth. At 9:29 AM, the resident was attempting to rotate the tray to reach other items at the back of the tray. While drinking from a cup, the resident took breaths and tilted the cup for small sips. During an interview on 4/22/2024 at 10:10 AM, certified nurse aide #30 stated they floated to the unit that day and the licensed practical nurse wrote down resident needs on their assignment sheet. Any resident eating in bed should be properly positioned upright to prevent aspiration (inhaling food/fluids into the lungs) of food or drinks. During an interview on 4/22/2024 at 10:20 AM, certified nurse aide #64 stated they floated to the unit for this shift. Resident specific care was documented in the care plan and care instructions. Residents eating in bed had to be positioned upright. Their tray table should be a comfortable height to eat from and not at chin level or higher. The resident had not expressed to them a desire to be out of bed prior to eating. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2024 at 10:33 AM, licensed practical nurse #31 stated resident specific care was in the care instructions. Awake residents should be out of bed for breakfast unless they did not want to. Any resident needing assistance with eating should be out of bed. If a resident ate in bed, they should be sitting upright with the tray table at chest height to enhance access to meal tray. The aides should round the unit during meals to ensure residents were not having difficulty eating. The nurse had seen the resident slumped in bed having difficulty eating in the past and immediately corrected the situation. During an interview on 4/22/2024 at 10:46 AM, registered nurse Unit Manager #27 stated care plans were updated by the Unit Manager and the appropriate disciplines. Cognitive residents were asked each meal if they wanted to get out of bed for the meal. Resident #133 was able to voice their preference and typically did not want to get out of bed for breakfast. Staff delivering meal trays should ensure the resident was positioned fully upright for the meal and not sliding down in bed during the meal. They stated they rounded the unit during breakfast, the resident was sitting up in bed with pillows under their arm and did not ask to be pulled up in bed. Resident #133 had use of 1 arm to eat and had a difficult time reaching the meal tray with that arm. 2) Resident #124 had diagnoses including epilepsy (seizure disorder), contractures of both hands (tightening of muscle, tendons, ligaments), and morbid obesity. The 3/6/2024 Minimum Data Set assessment documented the resident was cognitively intact, had functional limitations in both arms and legs, used a wheelchair, was dependent for toileting and hygiene, required maximal assistance for upper body dressing/personal hygiene (such as combing hair/shaving), and received physical therapy. The 2/2/2024 updated comprehensive care plan documented the resident was at risk for alteration in skin integrity, was able to make own preferences and choices, had left hemiplegia (one-sided weakness), and had activities of daily living deficits. Interventions included keep skin clean and dry, weekly skin checks by nurse, observe skin with routine care, honor preferences, range of motion with care, physical therapy referrals as needed, provide sponge bath when a full bath could not be tolerated, check fingernail length and trim/clean on bath day and as necessary, dependence on 2 for scheduled shower day every Tuesday on evening shift, maximum assistance of 1 with personal hygiene, and dependence of 1 with upper body dressing. During an observation on 4/15/2024 at 12:32 PM, Resident #124 had a full beard and stated they were supposed to be shaved today. They preferred to be shaved at least every other day, but they were not. The resident stated they were unable to shave themselves and their beard was itchy. They stated they scratched their face when itching due to long, sharp fingernails. The 4/17/2024 care instructions documented the resident was dependent for upper and lower body dressing, 2 staff for all care due to behaviors, bilateral palm grips during sleep, make sure hands were clean, provide regular range of motion on fingers of both hands, maximum assistance of 1 for personal hygiene, dependence of 2 for shower/bath every Tuesday on evening shift, and keep skin clean and dry. The following observations of Resident #124 were made: (continued on next page)

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	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 4/17/24 at 9:12 AM, lying in bed eating breakfast with certified nurse aide #65 sitting in the room supervising. The resident's hair appeared greasy and tangled with white flakes. The resident stated they were given a bed bath the evening before. The resident's fingernails were grown to the tips of the fingers and had pointed edges in various areas on each nail. - on 4/18/24 at 8:30 AM, in their room sitting in a wheelchair. The resident's hair was uncombed, and their fingernails were unkept. - on 4/19/24 at 10:00 AM, resting in bed. Their fingernails were unkept and had brown debris underneath. Their hair appeared greasy and there was facial stubble about 1/8 inch long. The 4/2024 nurse aide task documented the resident was provided personal hygiene every day shift and most evening shifts, received upper body dressing every day shift and most evenings, had a skin observation done every day shift and most evenings and nights. The resident received a shower/bath on evening shifts of 4/15/2024 and 4/16/2024. During an interview on 4/29/24 AM at 2:05 PM, registered nurse Unit Manager #66 stated each resident was scheduled for a bath or shower once a week and as needed. If the bath/shower was refused by the resident, a bed bath was offered. If a bed bath was given, the resident's hair was washed using a shower cap. Resident activities of daily living preferences were obtained from the resident or representative upon admission and then quarterly and entered the care plan and care instructions. Certified nurse aides were expected to review each assigned resident's care instructions daily prior to resident care, unless they were full time on the unit and familiar with the resident, then they should review them weekly. Any changes to the care instructions were discussed during morning report. Unit nurses were responsible to ensure all care was provided. The Unit Manager and Assistant Unit Managers rounded frequently on the unit to ensure care was done. Weekly skin checks were done by a unit nurse on shower/bath days for each resident. Nail care was done on shower days and nails should be trimmed as needed according to resident preferences. Facial hair should be trimmed or shaved per resident preferences on shower days and as needed. Facial hair length was also based on resident's preferences and preferences, such as having a beard or whiskers, should be in the care plan. Nails should be no longer than the tips of the fingers and filed smooth to prevent scratches. Resident #124 only wanted bed baths and often refused shaving. This should be in the care plan and instructions and documented as refusals. Hair washing was included in the shower/bath task and fingernail care and shaving were in the personal hygiene task. Resident #124's hair should not have been greasy unless they refused to have their hair washed. During an interview on 4/29/2024 at 2:15 PM, certified nurse aide #63 stated resident specific care was documented in the resident's care instructions and was reviewed daily. They stated they reviewed each resident's instructions prior to entering the room to provide care. Each resident should receive a shower/bath weekly according to the unit shower list. The unit nurse performed a skin check with each bath/shower. Nail care, hair washing, and shaving were to be done on the bath/shower day. Residents should also be shaved when facial hair was clearly visible or per resident preferences. If a resident refused care, staff were to reapproach and tell the nurse if the refusal continued and documented in the medical record. Any nursing staff could trim nails unless otherwise specified. Resident #124 usually asked when they wanted to be shaved. They stated they noticed Resident #124's hair was greasy in appearance and offered to wash it on 4/29/2024 in the morning. If a resident was given a bed bath, staff were to wash their hair using a shower cap washing device. Nails should be trimmed so the resident did not scratch themselves with long nails. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/2024 at 2:25 PM, licensed practical nurse #67 stated skin checks, nail care, and hair care were done on a resident's bath/shower day. If a resident refused care, the aide told the nurse who would reapproach the resident. All refusals were documented in the task section and a progress note made by the nurse. Nurses were responsible for ensuring resident care was completed by the aides as planned. Resident rounding was done by the nurse when performing resident care such as treatments and medications. Any issues were addressed with the aide. They stated they checked Resident #124 that morning and noted they had greasy hair. Aides were allowed to trim nails unless the resident was diabetic, and Resident #124 was not. Nails should be trimmed when at the tip of the finger or longer. If a resident refused a bath/shower after reapproaching, they generally did not get one until the next week. Hair care and nails could be done anytime and by any nursing staff. 3) Resident #384 had diagnoses including hemiplegia (one-sided weakness), obesity, and diabetes. The 4/11/2024 Minimum Data Set assessment documented the resident was cognitively intact, required substantial assistance for bathing and toileting, and did not refuse care. The 3/24/2024 comprehensive care plan documented a deficit with self-care related to fatigue. Interventions included to encourage the resident to participate in care. The resident was alert and oriented and able to make decisions regarding their care. During an interview and observation on 4/15/2024 at 4:18 PM, Resident #384 was unshaven. They stated they only received a shower once a week and did not receive one on 4/12/2024 as scheduled. The usual certified nurse aide was off, and they did not get washed up that day. There was a strong smell of urine in the room. The certified nurse aide task record for Resident #384 was not signed as completed on 4/12/2024. There was no progress note documenting the resident refused their shower 4/12/2024. During an interview and observations on 4/16/2024 at 8:14 AM, Resident #384 stated there was emesis on the floor. They stated the call bell had been on since 7:30 AM that morning and staff had not answered it yet. The call light was on. There was emesis with food particles on the floor. The room smelled of urine and the resident's urine drainage bag was half full. Staff entered the room at 8:22 AM to answer the call light and the nurse cleaned up the emesis at that time. At 9:58 AM, the resident was in bed and there were large yellow spots on the right side of the bed sheets. The resident stated they had vomited on that area of the sheets. At 3:13 PM, the resident was sitting in a chair. The resident stated they had been washed but they had not received a shower and would like one. There was a large wash basin in the room with a yellow liquid. The resident stated they had vomited in the basin. During an interview on 4/17/2024 at 9:40 AM, certified nurse aide #5 stated showers were on the schedule at the nursing station. A resident not receiving activities of daily living would have poor hygiene which could cause an infection and was undignified. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/19/2024 at 10:57 AM, registered nurse Unit Manager #14 stated care refusals were documented in the care plan. A refusal intervention was to reapproach the resident and notify the nurse for documentation purposes. Nail care, shaving and hair washing were done as needed even if not on their scheduled shower day. Repercussions of not providing appropriate care included pneumonia, infection, tooth decay, overall feelings of uncleanliness, negative psychosocial effects, and dignity issues. They expected that all planned care be provided. During an interview on 4/22/2024 at 9:06 AM, licensed practical nurse #44 stated the aides provided residents a shower on their assigned shower day. Residents should be washed each day. Resident #384 should have received a shower on 4/12/2024. They stated there were times when scheduled showers were not done by a certified nurse aide who was covering for a regular aide. Resident #384 was assigned a shower each Friday. The resident never refused a shower since they had been caring for them. During a follow-up interview on 4/22/2024 at 9:36 AM, registered nurse Unit Manager #14 stated if a resident did not get a shower and wanted one, it could impact their overall feelings of wellness, skin breakdown, and infection prevention. They expected that each resident received their shower on their scheduled day. Resident #384 did not refuse care and was cognitively intact. It was not acceptable that the resident put the call light on at 7:30 AM and staff did not answer it until 8:22 AM. 10NYCRR 415.12 (a)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37516 Based on observation, record review and interview during the recertification and abbreviated surveys (NY00318518, NY00318847, NY00320334, NY00331963, and NY00338231) the facility did not ensure each resident received adequate supervision and the environment remained as free of accident hazards as possible for 2 of 9 residents (Residents #117 and #323) reviewed. Specifically, Resident #117 was found on the floor between their bed and the wall due to the bed brakes not being locked; and Resident #323 had a history of sexually inappropriate behaviors and propelled their wheelchair independently throughout the facility without an adequate supervision plan. Findings include: The facility policy Resident Abuse Reporting, dated 8/1/2023, documented each resident had the right to be free from all types of abuse, neglect, misappropriation of resident property, and exploitation. The facility policy Off Unit/Leave of Absence, dated 10/2023, documented the resident must notify nursing on the unit and sign out in the resident sign out book when the resident was off the unit, so staff knew their location within or outside the facility. The facility policy Adverse Incident Policy, dated 12/27/2023, documented all adverse incidents would have investigations and care plan interventions to ensure the residents' environments were free from accident hazards and to ensure each resident received adequate supervision. The facility policy Fall Risk Evaluation, Fall Prevention, Management and Standards of Care, dated 1/3/2024, documented registered nurses and licensed practical nurses were responsible for ensuring the care planned interventions were in place and functioning at the time of the assessment and documenting whether they were in place or not at the time of the assessment. The fall care plan would undergo a comprehensive review of the fall prevention interventions quarterly, annually, with a significant change and after the resident experienced a fall. Standard of care included bed in lowest position with brakes on, use floor mats when appropriate, and increase rounding schedule according to the residents' needs. 1) Resident #117 had diagnoses including anoxic brain damage (lack of oxygen to the brain), tracheostomy (opening into the trachea for breathing assistance), and gastrostomy (opening into the stomach for nutrition). The 2/24/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had upper and lower extremity impairment on both sides, was totally dependent for bed mobility, did not ambulate, and had a fall since admission/entry or re-entry or the prior assessment. The resident's Fall Risk Evaluation dated 5/2/2023, documented upon admission and quarterly, at a minimum thereafter, to evaluate the resident's fall risk. If the total score was 3 or greater the resident should be considered at risk for potential falls. The resident scored a 24. There were no additional Fall Risk Evaluations. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan initiated on 1/2/2023 and revised on 11/20/2023 documented the resident had a history of falls with no injury related to poor balance and poor communication/comprehension. Interventions included black mat at bedside, continue interventions on the at-risk plan, and for no apparent acute injury determine and address causative factors of the fall. There was no documentation addressing the position of the bed with the left side of the bed against the wall or what side of the bed the fall mat was to be placed. The certified nurse aide care instructions as of 1/20/2024 documented the resident was non-ambulatory, check and change for incontinence every 2 - 3 hours and as needed, and was dependent with the assistance of 2 for rolling left to right in the bed, and assistance of 2 for care at all times. An incident report dated 1/20/2024 at 4:15 AM by registered nurse #35 documented that at 4:15 AM they were notified by the team nurse that the resident was on the floor. On assessment they found the resident lying on the floor near to the wall side, their tube feeding was on, and the gastric tube was intact. No discomfort or apparent injuries were noted. The resident had no distress. The bed was in the low position, but it was not locked. Under Immediate Action Taken the resident was placed back to bed with the assistance of the mechanical lift. Staff was re-educated. The family was notified and wanted the resident sent to the hospital. Nurse practitioner #37 was notified, an ambulance was called and arrived at the facility at 7:47 AM. No injuries were observed post-incident. A 1/20/24 at 5:45 AM progress note by registered nurse #35 documented at 4:15 AM they were notified by the team nurse that the resident was on the floor. On assessment they found the resident lying on the floor near to the wall side, tube feeding on, and the gastrostomy tube was intact. No discomfort or apparent injuries were noted. The resident was placed back to bed with the assistance of the mechanical lift. The resident had no distress. Employee Statement Forms dated 1/20/2024 documented: - licensed practical nurse #39 found the resident lying on the floor at 4:15 AM while doing rounds. The last time they had observed the resident was at 3:00 AM when they were asleep in bed. - certified nurse aide #38 last observed the resident at 2:00 AM during incontinence care. After providing care they put the resident closest to the wall with the bed in low position and forgot to lock the brakes on the bed. There was no injury after the fall. The comprehensive care plan initiated on 1/22/2024 documented the resident was at high risk for falls related to gait/balance problems, incontinence, poor communication/comprehension, unable to make needs known, and poor trunk control related to anoxic brain damage. Interventions included keep bed in lowest position or at wheelchair height, fall mat next to bed while in bed, anticipate and meet the resident's needs, ensure resident was properly positioned while in bed and in chair due to poor trunk control, and in the event of a fall follow facility fall protocol and monitor/document/report as needed for 72 hours to physician. There was no documentation addressing the position of the bed with the left side of the bed against the wall, what side of the bed the fall mat was to be placed, or to ensure the bed was locked when the resident was in it. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The certified nurse aide care instructions as of 4/22/2024 documented under the topic of safety: - Fall risk. - Keep bed in lowest position or at wheelchair height. - Fall mat next to bed while in bed. There was no documentation addressing the position of the bed with the left side of the bed against the wall, what side of the bed the fall mat was to be placed, or to ensure the bed was locked when the resident was in it. A 1/30/24 at 12:52 PM progress note by registered nurse Unit Manager #40 documented after further review the care plan was in place but not functioning. The certified nurse aide was re-educated on the importance of ensuring safety interventions were in place prior to leaving the room. The resident was sent to the emergency department per family's request and was evaluated and returned to the facility. Resident was without any injuries and was at baseline at that time. The incident was avoidable. A 1/30/2024 Record of Verbal Counseling given by registered nurse Unit Manager #40 to certified nurse aide #38 documented to be mindful when leaving a room to check if safety precautions were in place such as the bed being locked and in low position and that other safety interventions were completed. On 4/15/2024 at 11:17 AM Resident #117 was observed asleep in their bed. The bed was in the lowest position with the left side of the bed against the wall, a fall mat was on the right side of the bed, a tube feeding pump with the tube feeding disconnected was on the right side of the bed, the bed brakes were locked, and the head of the bed was at 45 degrees. Registered nurse Unit Manager #40 entered the room and stated that sometimes the resident shimmied to the edge of the bed and recalled one time in the last year that the resident had rolled out of the bed without injury. Staff used to do rounds every 2 hours on the resident but checked on them at least once an hour after the resident had rolled out of their bed. They could not recall the specific date when the resident had last rolled out of their bed. During observations on 4/16/2024 at 10:28 AM and on 4/17/2024 at 11:19 AM the resident was in their bed with the left side of the bed against the wall with the fall mat on the right side of the bed. During an interview on 4/17/2024 at 3:23 PM registered nurse Unit Manager #40 stated the staff involved in the 1/20/2024 incident was certified nurse aide #38. They reviewed a copy of the 1/20/2024 incident report and stated the last time certified nurse aide #38 had observed the resident was at 2:00 AM. They stated the incident was a result of a care plan violation. The resident did not receive an injury. They were not sure if certified nurse aide #38 was suspended from work, if the incident needed to be reported to the Department of Health, or if certified nurse aide #38 even worked at the facility anymore. Licensed practical nurse Assistant Unit Manager #33, who was nearby, stated certified nurse aide #38 still worked at the facility on the night shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/18/2024 at 12:03 PM licensed practical nurse #39 stated they recalled the 1/20/2024 incident. When they were doing rounds, they found Resident #117 on the floor on the wall side next to the bed. The bed was not locked. The resident slid off the bed pushing against the wall. The resident was on the floor, close to the left side of the bed and the wall. They called the charge nurse. The resident's family was notified, and they wanted the resident sent to the hospital to be evaluated to make sure they were okay. The last time they had observed the resident prior to the incident at 4:15 AM was around 3:00 AM for tracheostomy care. During an interview on 4/19/2024 at 12:45 PM the Director of Staff Education and Development stated starting in February 2024 if staff had a care plan violation they would be directed to their department for re-education. Before February 2024 Unit Managers were responsible for staff education. They were not sure what kind of documentation or where that documentation would be if Unit Managers did any re-education of staff due to a care plan violations. During an interview on 4/19/2024 at 1:16 PM with licensed practical nurse Assistant Unit Manager #33 stated the 1/20/2024 incident involving Resident #117 was an unwitnessed fall. Sometimes verbal counseling of staff was considered the re-education. Not all unwitnessed falls required an investigation, it depended on the circumstances and what was involved in the fall. Any incident report went to Assistant Director of Nursing #42 for review. The bed brakes not being locked was considered a policy violation and not a care plan violation. The resident could have fallen out of the bed from coughing. The momentum from coughing could have caused the resident to shift in bed resulting in the fall. During an interview on 4/22/2024 at 10:53 AM Assistant Director of Nursing #42 stated the 1/20/2024 incident was considered a policy violation and not a care plan violation. Resident #117 had no history of falling out of bed. The bed was not locked which is why they fell out of bed. The resident had no trunk control and when they coughed their body moved. Certified nurse aide #38's statement documented they did not lock the resident's bed before leaving their room. The resident's bed was positioned with the left side of the bed against the wall when the incident occurred. They were not sure if it could have been a potential accident hazard concern because they did not know how far the bed had moved when the resident was found lying on the floor between the left side of the bed and the wall. During a follow-up interview on 4/22/2024 at 1:28 PM licensed practical nurse Assistant Unit Manager #33 stated they were not sure why the resident's left side of the bed was positioned against the wall, it had always been that way, even when the resident was in a different room on the unit. The fall on 1/20/2024 was an isolated incident. They could not state why the bed position was not specified in the care plan or how often fall evaluations were done on residents. The last fall evaluation done for Resident #117 was on 5/2/2023. During an interview on 4/23/2024 at 12:20 PM the Director of Nursing stated residents received fall evaluations quarterly, if they had a fall, or if there was a change in the resident, such as leaning or unsteadiness. The facility had weekly fall meetings. The Unit Manager would read the incident report at the meeting then would have three days to close it out. They expected the plan for the resident's bed to be positioned against the wall be clearly documented in the care plan. If staff stated, they forgot to lock the bed it would be a policy violation and they expected certified nurse aide #38 to be re-educated on the care plan/policy violation by the Unit Manager or the staff education department. The disciplinary form was separate from the re-education documentation. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #323 had diagnoses including severe dementia with behavioral disturbances, hemiplegia, and hemiparesis (weakness/paralysis on one side of the body) and wandering. The 2/8/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required supervision for transfers, and was independent with wheelchair use for mobility. The 5/25/23 physician order documented nurses were to document the resident's behaviors every shift and notify the Assistant Director of Nursing immediately for any behaviors of inappropriate touching toward another resident. The 1/24/2024 physician's order documented the resident moved from the 4th floor to the 13th floor. The comprehensive care plan, revised 1/25/2024, documented the resident had a behavior problem of inappropriate physical and sexual contact and sexually inappropriate behavior related to vascular dementia. Interventions included to not seat the resident near female residents during meals or activities, monitor behavior episodes, and intervene as necessary to protect the rights and safety of others. The certified nurse aide care instructions documented to not seat the resident near female residents during activities or at mealtimes. Resident #323 had the following documented incident reports for inappropriate touching of other residents: - on 8/19/2021 the resident was witnessed touching a confused resident's breasts with both hands. - on 10/8/2021 the resident was observed kissing the cheek of a resident who was unable to consent. - on 7/28/2022 at 11:30 PM, the resident was observed in another resident's room. The other resident was in bed and their hand was on Resident #323's groin area. Resident #323 denied anything had occurred. - on 5/24/2023, the resident was observed touching a confused resident under their shirt around the breast area. - on 7/10/2023, the resident was observed brushing their hand down a confused resident's left shoulder down their body to their hand. - on 12/11/2023 at 2:20 AM, the resident was found in another resident's room caressing the confused, unclothed resident. Resident #323's behaviors notes documented: - on the 4/16/2024 evening shift the resident was on and off the unit throughout the shift. - on the 3/13/2024 night shift the resident left the floor several times throughout the night. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on the 3/12/2024 night shift the resident was in another resident's room having a conversation and no inappropriate behavior was noted. The resident was informed they could not be in that resident's room and was directed to leave. - on the 3/9/2024 night shift the resident left the unit at 11:58 PM and returned to the unit at 12:16 AM. - on the 3/8/2024 night shift the resident left the unit at 12:03 AM, returned at 12:16 AM, left again at 1:52 AM and returned at 2:06 AM, and then left again at 3:26 AM and returned at 4:20 AM. - on 3/4/2024 night shift the resident left the unit at 2:32 AM and returned to the unit at 3:55 AM. - on 2/22/2024 night shift the nurse was contacted by the Nursing Supervisor to inquire where the resident was. Security had been informed that the resident had taken food from the basement cafeteria, and they were looking for the resident. The following observations and interviews were made: - on 4/15/2024 at 4:28 PM, the resident was not in their room. Registered nurse Unit Manager #27 stated the resident was not on the unit and was probably outside or in lobby. The resident liked to be out there and spent all day off the unit. - on 4/16/2024 at 9:10 AM, the resident was seated at a table in the dining room across from a female resident. At 11:08 AM, the resident was outside in their wheelchair next to a male resident and a female resident. - on 4/17/2024 at 3:59 PM, the resident was not in their room. Registered nurse Unit Manager #27 stated the resident was all over the building. They stated the resident went down to socialize on the 7th floor and social worker #29 frequently visited them on the 10th floor. Registered nurse Unit Manager #27 stated if the resident's stop sign on their room door was down, they usually were not in their room. The resident usually said hello to the staff and then was gone from the unit. At 4:11 PM, the resident was observed in their wheelchair outside the facility near a picnic table with a female resident. - on 4/18/2024 at 9:21 AM, the resident was in bed with sheet pulled over their head. The resident stated they were off the unit a lot but denied going to other units. They stated they were independent using the elevator. At 9:22 AM, Registered Nurse Unit Manager stated the resident was social and was all over the building, so they were hard to track down. At 4:46 PM, the resident was outside in their wheelchair in an alcove of the building. - on 4/19/24 at 1:15 PM, the resident was in their wheelchair in the front entrance to the building. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2024 at 10:10 AM, certified nurse aide #30 stated they knew what care a resident needed by the written-out list the nurse provided but they also looked at the resident's care instructions. They stated if a resident left the unit, they had to sign out so that nursing staff was able to keep track of them. They were unaware of any behaviors or special instructions for Resident #323. They stated the resident was independent with a lot of their care, so they only had to check on them and make sure the resident did not need anything. During an interview on 4/22/2024 at 10:33 AM, licensed practical nurse #31 stated they knew how to care for a resident based on their care instructions or care plan. They stated if a resident left the unit, the resident let the staff know. If they were leaving the facility property, they had to sign out. They stated Resident #323 did not always let them know they were leaving the unit but usually told staff. They stated they knew the resident went outside but also went to other units. They stated they were not able to monitor the resident's behavior consistently but staff from other units informed them if there were issues. They were not aware of the resident's care plan intervention to not be placed next to female residents during meals or in activities. They were not aware of how the care plan intervention was followed in other parts of the facility as it would have to be communicated to all floors. During an interview on 4/22/2024 at 10:46 AM, registered nurse Unit Manager #27 stated they did not always know when Resident #323 left the unit. They stated the nursing staff knocked on the resident's door to see if they were on the unit. The resident liked to sit outside or in the facility foyer. When the resident was on the floor, they did not have any behaviors, but the nurses should document the resident was off the floor. The resident had a care intervention not to sit with female residents. They stated the intervention was loosely followed because there was a resident who was alert and able to make their needs known who Resident #323 visited in their room and sat next to. Any resident who went outside was alert and orientated so the care plan intervention would not need to be enforced since the residents could make their needs known. During an interview on 4/22/2024 at 12:51 PM, social worker #29 stated the resident was transferred from the 4th floor to the 13th floor a few months ago due to inappropriate behaviors on the 4th floor. They stated the resident was moved from the 4th floor to the 13th floor so intense supervision monitoring could be discontinued. They stated they had expressed concerns as the resident independently utilized the elevator but was told by administration that the resident's monitoring was adequate. They were unsure how the resident was being monitored off the unit and they were unaware if other units were made aware the resident needed to be monitored near females. During an interview on 4/22/2024 at 3:18 PM, the Director of Social Work stated Resident #323 had a history of inappropriate touching. They stated they were unsure why the resident was moved from the 4th floor to the 13th floor. If a care plan intervention stated the resident was not to be placed next to female residents for activities or at mealtimes, it applied to all female residents, including cognitively intact residents. During an interview on 4/22/2024 at 3:45 PM, the Director of Nursing stated Resident #323 had several incidents of inappropriate touching of other residents. They stated the resident was moved from the 4th floor to the 13th floor because the bigger setting of the 4th floor overwhelmed the resident. The resident had independent use of the elevator but the staff on the 4th floor knew the resident and would redirect them off the floor. They were not concerned the resident moved freely from floor to floor in the buildings and if the staff reported any issues, they would address it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2024 at 4:26 PM, the Administrator stated Resident #323 was moved from the 4th floor to the 13th floor for a better environment. The resident's care plan intervention not to be seated next to female residents was specific to their unit only. They stated the resident independently utilized the elevator, but the resident's care plan could be viewed electronically on any unit they went to. They expected nursing staff to know when the resident left the unit and where the resident planned to go. The Assistant Directors of Nursing should communicate with the Nursing Supervisors and Unit Managers to make sure the resident's behavior was monitored. During an interview on 4/23/2024 at 9:54 AM, Assistant Director of Nursing #18 stated Resident #323 was moved to floor 13 from the 4th floor in the [NAME] building as the environment was quieter and had more alert residents. They stated the resident spent most of their time off the unit and going throughout the building. They stated the resident came back to eat and would visit with other residents on other floors or go outside. During an interview on 4/23/2024 at 10:31 AM, Assistant Director of Nursing #23 stated the resident's care plan to not be seated next to females during an activity or during a mealtime only applied to the resident's current unit and was not enforced throughout the rest of the building. The nursing staff should monitor the resident's behaviors on the unit, and they expected the other units to report to a Nursing Supervisor if there was a concern with the resident's behavior. They stated the managers were aware of the resident's history of behaviors and all the units had access to the electronic medical record to look up the resident's plan of care. They stated the resident had not had an issue since they moved to the 13th floor and the resident's behaviors were always on the resident's home unit, not other floors. 10 NYCRR 483.25(d) 48052 2) Resident #323 had diagnoses which included severe dementia with behavioral disturbances, hemiplegia and hemiparesis (weakness on one side of the body) of the right dominant side and wandering. The 2/8/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was supervision for transfers, and independent at wheelchair level for mobility. The 5/25/23 physician's order documented the nurses were to document the resident's behaviors every shift. The nurses were to notify the Assistant Director of Nursing immediately for any behaviors of inappropriate touching toward another resident. The 1/24/2024 physician's order documented the resident moved from 4th floor to 13th floor of the [NAME]. The comprehensive care plan, revised 1/25/2024, documented the resident had a behavior problem of inappropriate physical and sexual contact and sexually inappropriate behavior related to vascular dementia. Interventions included to not sit the resident near female residents during meals or activities, to monitor behavior episodes, and to intervene as necessary to protect the rights and safety of others. The certified nurse aide care instructions documented to not sit the resident near female residents during activities or at mealtimes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record review on 4/23/2024 at 8:26 AM documented the resident had the following incident reports for the inappropriate touching of another resident: - On 8/19/2021 the resident was witnessed touching a confused resident's breasts with both hands. - On 10/8/2021 the resident was observed kissing the cheek of a resident who was unable to consent. - On 7/28/2022 at 11:30 PM, the resident was observed in another resident's room with a confused resident's hand on their groin area while the confused resident was in bed. Resident #323 denied anything had occurred. - On 5/24/2023, the resident was observed touching a confused resident under their shirt around the breast area. - On 7/10/2023, the resident was observed brushing their hand down a confused resident's left shoulder down their body to their hand. - On 12/11/2023 at 2:20 AM, the resident was found in another resident's room caressing a confused unclothed resident. Resident had behaviors notes which documented: - On the 4/16/2024 evening shift the resident was on and off the unit throughout the shift. - On the 3/13/2024 night shift the resident had left the floor several times throughout the night. - On the 3/12/2024 night shift the resident was in another resident's room having a conversation and no inappropriate behavior was noted but resident was informed they could not be in that resident's room and was directed to leave. - On the 3/9/2024 night shift the resident left the unit at 11:58 PM and returned to the unit at 12:16 AM. - On the 3/8/2024 night shift the resident left the unit at 12:03 AM, returned at 12:16 AM, left again at 1:52 AM and returned at 2:06 AM, and then left again at 3:26 AM and returned at 4:20 AM. - On 3/4/2024 night shift the resident left the unit at 2:32 AM and returned to the unit at 3:55 AM. - On 2/22/2024 night shift the nurse was contacted by the nursing supervisor to inquire where the resident was. Security had been informed that the resident had taken food from the basement cafeteria, and they were looking for the resident. Observations and interviews were made of the resident: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 4/15/2024 at 4:28 PM, the resident was not in their room. Registered nurse/Nurse Manager #27 stated the resident was not on the unit and was probably outside or in lobby. The resident liked to be out there and spent all day off the unit. - On 4/16/2024 at 9:10 AM, the resident was sat at a table in the dining room across a small table from a female resident. At 11:08 AM, the resident was observed sat outside in their wheelchair next to a male resident and a female resident. - On 4/17/2024 at 3:59 PM, the resident was not in their room. Registered nurse/Nurse Manager #27 stated the resident was all over the building. They stated the resident goes down to socialize on the 7th floor and social worker #29 stated visited them on 10 frequently. Registered nurse/Nurse Manager #27 stated if the resident's stop sign was down, they usually weren't in their room. The resident usually said hello to the staff and then was gone from the unit. They stated they were unsure what floor the resident was on. At 4:11 PM, the resident was observed in their wheelchair outside the facility near a picnic table with a female resident. - On 4/18/2024 at 9:21 AM, the resident was in bed with sheet pulled over their head. Resident stated they were off the unit a lot but denied going to other units. They stated they were independent with the use of the elevator. At 9:22 AM, Registered Nurse/Nurse Manager stated the resident was social and were all over the building, so they were hard to track down. At 4:46 PM, the resident was outside in their wheelchair in an alcove of the building. - On 4/19/24 at 1:15 PM, the resident was observed in the front entrance to the building in their wheelchair. During an interview on 4/22/2024 at 10:10 AM, certified nurse aide #30 stated they knew what care a resident needed by the written-out list the nurse had provided but they also looked at the resident's care instructions. They stated if a resident was to leave a unit, they had to sign out so that the nursing staff was able to keep track of the resident. They were unaware of any behaviors or special instructions Resident #323 had. They stated the resident was independent with a lot of their care, so they only had to check on the resident and make sure the resident hadn't needed anything. During an interview on 4/22/2024 at 10:33 AM, licensed practical nurse #31 stated they knew how to care for a resident based on their care instructions or care plan. They stated if a resident left the unit, the resident let the staff know. If they were leaving the facility property, they had to sign out. They stated Resident #323 did not always let them know they were leaving the unit but usually told staff. They stated they knew the resident went outside but they also went to other units. They stated they are not able to monitor the resident's behavior consistently but staff from other units informed them if there were issues. They were not aware of the resident's care plan intervention to not be placed next to female residents during meals or in activities. They were not aware of how the care plan intervention was followed in other parts of the facility as it would have had to been communicated to all floors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 4/22/2024 at 10:46 AM, registered nurse/Nurse Manager #27 stated residents let the nursing staff know when they left the units and they had to sign out if they left the facility property. They stated they did not always know when Resident #323 left the unit. They stated the nursing staff knocked on the resident's door to see if they were on the unit or not. They stated the resident liked to sit outside or in the facility foyer. They stated they were unsure how the nurses were able to monitor the resident's behaviors since he was off the unit for a lot of the shifts. They stated when the resident was on the floor, they hadn't had any behaviors, but they nurses should have documented the resident was off the floor if they weren't on the unit. They were unaware of any behavior interventions in place for the resident but stated they would check the resident's chart. They stated the resident had a care intervention not to sit with female residents. They stated the interven[TRUNCATED]

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48052 Based on observation, interview, and record review during the recertification and abbreviated (NY00329469, NY00331762, NY00330471) surveys conducted 4/15/2024-4/23/2024, the facility did not ensure pain management was provided to residents who required such services consistent with professional standards of practice for 1 of 2 residents (Resident #168) reviewed. Specifically, Resident #168 did not receive adequate pain management following a fall with a hip fracture. Findings included: The facility policy Pain Assessment, Management, and Evaluation dated 8/24/2022, documented the interdisciplinary team identified residents in need of pain management and completed on-going assessments to control the resident's pain. All residents would have a pain assessment completed upon admission, quarterly, annually, and with a significant change. Resident #168 had diagnoses including Alzheimer's disease, weakness, and osteoarthritis (degeneration of joints). The 10/22/2023 Minimum Data Set assessment documented the resident had severely impaired cognition, was independent with ambulation, and had no indicators of pain. A 12/23/2023 at 10:35 AM incident report completed by registered nurse #45, documented another resident pushed Resident #168. Resident #168 fell backwards to the ground. Resident #168 complained of pain in the left hip and knee. The resident was assisted off the floor by 2 staff into a wheelchair. The provider was called and ordered an X-ray of the left knee and hip. The resident's level of pain was a 3 on the Pain Assessment in Advanced Dementia scale (1-3 indicates mild pain). A 12/23/2023 at 2:59 PM licensed practical nurse #46 progress note documented the resident complained of pain in their left hip and knee. There was no documented evidence the resident's level of pain was evaluated or pain management was provided. A 12/24/2023 at 2:31 PM licensed practical nurse #46 progress note documented the resident still complained of pain in the left hip and knee. The resident was in lots of pain when staff tried to care for them. There was no documented evidence the resident's level of pain was evaluated or pain management was provided. A 12/24/2023 at 10:26 PM licensed practical nurse #47 progress note documented the resident had complaints of pain in their left hip and knee and the resident was non-weight bearing. There was no documented evidence the resident's level of pain was evaluated or pain management was provided. A 12/25/2023 at 11:36 AM licensed practical nurse #48 progress note documented they were called to the floor as the resident's family member asked about the outcome of the resident's fall and pain in their left hip. Licensed practical nurse called the radiology company to obtain the results of the x-ray. The resident was observed lying on their back with a complaint of left hip pain when range of motion was attempted. Internal rotation was noted. The registered nurse Supervisor came to assess the resident. The radiology company was called again for results. The radiology company called back, and a left hip fracture was noted. The resident's family member requested the resident be sent to the hospital. The registered nurse called the provider and awaited a call back. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/25/2023 at 12:58 PM licensed practical nurse #48 progress note documented the resident was sent to the hospital for evaluation of a left hip fracture. Physician orders active as of 12/25/2023 did not include strategies for pain management. The 12/2023 Medication Administration Record did not include administration of pain relief measures from 12/23/2023 through 12/25/2023. During an interview on 4/18/2024 at 10:13 AM, Resident #168's family member stated their sibling was notified by a nurse via phone that another resident had pushed the resident over, the resident was fine, and they were doing x-rays as a precaution. They stated their sibling called the facility three times to follow up on the x-rays but only received a voicemail from the nurse that assured them the resident was fine. They went to visit the resident on 12/25/2023 and the resident was lying in bed with one side of their face clenched tight. They stated they got a nurse who informed them the resident had a fall. They asked the nurse about the x-rays and the nurse informed them the x-rays had not been read. An hour or so later the nurse informed them the resident had a hip fracture. The family requested the resident be sent to the hospital. During an interview on 4/22/2024 at 1:31 PM, licensed practical nurse #52 stated they were the covering Unit Manager when the resident #168 was pushed by another resident. They were unaware if the resident was given any pain medication for reported pain on 12/23/2023 and 12/24/2023. They reviewed the resident's orders and medication administration record in the electronic medical record and stated the resident was not provided with pain medication. They stated a nurse should have contacted the provider for pain medication. During an interview on 4/22/2024 at 2:57 PM, physician #53 stated another resident had pushed over Resident #168 and the resident had an x-ray ordered. They stated if the nurses thought the resident needed pain medication or the resident complained of pain, they should have called for orders. They stated there was no note from a provider that pain medication was requested by nursing. During an interview on 4/22/2024 at 3:45 PM, the Director of Nursing stated they expected if a resident had a fall on 12/23/2023 and had pain with care on 12/24/2023, the nurses should have called the medical provider to obtain orders for pain medication. They reviewed the resident's chart and stated they did not see any orders for pain medication or pain management. 10NYCRR 415.12

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48895 Based on record review and interview during the recertification and abbreviated (NY00336003) surveys conducted 4/15/2024-4/23/2024, the facility did not ensure licensed nurses had the specific competencies and skills necessary to care for residents' need, as identified through resident assessments, and described in the plan of care for 3 of 5 licensed nurses (licensed practical nurse Unit Manager #4, licensed practical nurse Unit Manager #33, and licensed practical nurse #34) reviewed. Specifically, licensed practical nurse Unit Manager #4 did not have timely online training, annual competencies, or documented orientation competencies completed; licensed practical nurse Unit Manager #33 did not have annual competencies, or documented orientation competencies completed; and licensed practical nurse #34 did not received annual competencies that covered key skill-set areas as outlined in the facility assessment. Findings include: The 4/2024 Facility Assessment Tool documented nurse competencies in the facility included: person-center care, activities of daily living, disaster planning, infection control, medication administration, resident assessments, and specialized care in catheterization, colostomy care, oxygen administration, suctioning, [tracheostomy] care, tube feeding, wound care, and dialysis. The undated facility policy Educational Programs Competency Testing, documented all certified nurse aides and licensed nurses were competency tested according to their scope of practice in areas identified by Nursing Administration on a yearly basis. Competency was completed by a Nurse Educator, Nurse Manager, Clinical Coordinator, charge nurse, or designee. Any staff member that was competency testing another staff member must first be competent in the area being tested and have the competency on file with Nursing Education. Completed competencies were housed in the Department of Nursing Education. 1) Timely online learning modules Licensed practical nurse Unit Manager #4 had the following online trainings that were completed after the due date. - 2022 Code Silver training was due 8/31/22 and completed 4/19/2024. - 2023 corporate reorientation-supervisor was due 12/15/23 and completed 4/19/24. - Active shooter [New Employee Orientation] was due 2/28/24 and completed 4/19/24. - [Health Insurance Portability and Accountability Act for New Employee Orientation] was due 2/28/24 and completed 4/19/24. - Harassment: corporate reorientation for supervisors 2023 only was due 1/31/24 and completed 4/19/24. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [Health Insurance Portability and Accountability Act] do's and don'ts of social media and electronic communication was due 12/31/21 and completed 4/19/24. - [New Employee Orientation] corporate compliance was due 2/28/24 and completed 4/19/24. 2) Nursing skills competencies - Licensed practical nurse Unit Manager #4 did not have documented competencies from orientation and did not attend the competency/skills fair in 2023. - Licensed practical nurse Unit Manager #33 did not have documented competencies from orientation and did not attend the competency/skills fair in 2023. - Licensed practical nurse #34 did not attend the competency/skills fair in 2023. During an interview on 4/15/2024 at 11:07 AM, Resident #185 stated that nurses did not know how to change his ostomy (bodily waste passes through an opening in the abdomen into a pouch) appliances, and frequently had to use 3 or 4 appliances per change. They were concerned that they were only prescribed so many appliances and did not want to waste them. During an interview on 4/19/24 at 10:40 AM, licensed practical nurse #24 stated they had never had education for ostomy care or wound care in the facility. During a follow up interview on 4/23/2024 at 10:55 AM, licensed practical nurse #24 stated they did skill competencies when they were first hired, but only signed a paper monthly with in-service topics from Registered Nurse Unit Manager #28. During an interview on 4/23/2024 at 11:31 AM, certified nurse aide Education Coordinator #25 stated that half of the required trainings were completed on the computer. They were self-paced modules that took about 1 hour to complete but gave the staff 5 credit hours. The annual corporate orientation modules covered resident rights, abuse prevention, Alzheimer's disease/dementia/mental/behavioral health, infection control, safety, safe patient handling, corporate compliance and Health Insurance Portability and Accountability Act, respectful workplace, customer service, cybersecurity, communication, trauma informed care, social media, and workplace harassment. The competency/skills fair was the same for everyone. During an interview on 4/23/2024 at 11:46 AM, licensed practical nurse Nurse Educator #26 stated the only checklist competencies completed annually were at the skills fair once a year. There was an orientation checklist completed when staff was hired, but not again unless they attended the skills fair. They could not confirm a staff member was competent in a skill without the skills fair or checklist for the skill. Licensed practical nurse #26 confirmed the due date and completion dates for licensed practical nurse Unit Manager #4 and stated they were not completed timely. Electronic communication (email) with the Administer on 4/23/2024 at 2:19 PM, documented that licensed practical nurse Unit Managers #4 and #33 did not have completed competencies. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2024 at 2:22 PM, the Director of Nursing stated that nursing staff should have competencies completed annually, as they were mandatory. The education department tracked all nursing staff competencies. If they had not completed their annual competencies, they would be pulled off the schedule until they were completed. It was important to complete the competencies to ensure all licensed staff were updated and could perform the required tasks. The Unit Managers should also have competencies done annually. If there was a Unit Manager without completed competencies, the Director of Nursing would be notified. The Director of Nursing stated they were unaware that licensed practical nurse Unit Managers #4, and #33, and licensed practical nurse #34 did not complete annual competencies. 100% of licensed staff should complete competencies annually. 10 NYCRR 415.26(c)(1)(iv)

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	04/23/2024

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

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 Based on record review and interview during the recertification survey conducted 4/15/2024-4/23/2024, the facility did not ensure certified nurse aide performance reviews were completed once every 12 months for 2 of 5 certified nurse aides (certified nurse aides #20 and #21) reviewed. Specifically, there was no documented evidence certified nurse aides #20 and #21 who had worked for the facility more than 12 months, had performance reviews completed at least once every 12 months. Findings include: The facility policy Appendix A - [NAME] Code of Conduct, dated 5/2023 documented that each supervisor and manager was responsible for monitoring that their personnel were acting ethically and in compliance with applicable federal, state, or local statues, ordinances, executive orders, rules, regulations, judicial, or administrative decisions, ruling or orders, the facility's policies and procedures and the Code. All personnel were responsible for acquiring sufficient knowledge to recognize potential compliance issues applicable to their duties. The annual performance evaluation of each employee will include their compliance with both Health Insurance Portability and Accountability Act regulations and Corporate Compliance Program. Electronic communication on 4/19/2024 at 2:09 PM from the Administrator documented that certified nurse aides #20 and #21 did not have annual evaluations completed. During an interview on 4/22/24 at 1:14 PM, the Administrator stated that annual evaluations were the responsibility of the Unit Managers. If the certified nurse aide was per diem or float staff, the Assistant Director of Nursing was responsible for annual evaluations. During an interview on 4/22/24 at 3:16 PM, registered nurse Unit Manager #28 stated they were responsible for certified nurse aide evaluations, and they were done annually. Certified nurse aide #20 had a review a short while ago but they could not recall the date. There was a computer program that evaluations were completed in. They could not access evaluations once submitted or previous year evaluations for comparison. During an interview on 4/22/2024 3:55 PM, Assistant Director of Nursing #23 stated the Unit Managers were responsible for the certified nurse aide annual reviews. Registered nurse Unit Manager #28 should be able to see certified nurse aide #20's annual evaluation. During an interview on 4/23/2024 at 10:51 AM, certified nurse aide #20 stated they had worked as a certified nurse aide for almost 2 years and had never had an annual evaluation at the facility. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 4/23/2024 at 12:52 PM, the Director of Nursing stated that all staff had annual evaluations. There was no way for them to review evaluations if they were not the direct supervisor. All evaluations went to Human Resources who then reviewed them. They were unable to provide a blank version of the evaluation, but it was made up of 2 questions the first was about following the facility values, the second reflected the previous year. The options for answering were successful or not effective. The Nurse Manager had to generalize the information about the staff member in a narrative. If the Nurse Manager indicated not effective, there would have to be exact reasons, as this meant the staff member would be removed from the job. The Director of Nursing stated that Human Resources read each evaluation and determined what was needed for each staff member. During an interview on 4/23/2024 at 1:33 PM, the Chief People Officer (Director of Human Resources) stated they could not provide a copy of the evaluation form. The evaluation would just be a narrative, and they did not read each one. The evaluator was the person that determined the staff member's abilities. If it was determined by the evaluator they needed re-education, that would be the responsibility of Educational Services. 10 NYCRR 415.26 (d) (7)

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	335136	A. Building B. Wing	04/23/2024

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 48052 Based on observation, record review, and interview during the recertification survey conducted 4/15/2024-4/23/2024, the facility did not ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain and or maintain their highest practicable physical, mental, and psychosocial well-being for 1 of 1 resident (Resident #158) reviewed. Specifically, Resident #158 had a diagnosis of dementia and was not provided with preferred person-centered activities. Findings include: The facility policy Managing Behavioral Symptoms of Dementia, dated 4/29/2019, documented the facility was committed to ensuring that the needs of residents who experienced behavioral symptoms of dementia were met as much as possible. Behaviors often indicated unmet needs. Behaviors were no longer referred to as aggressive, disruptive, challenging, or difficult. Staff were to obtain history, favorite things, hobbies, personal interests to be included in non-pharmacological strategies and plans of care. A resident-centered plan of care would be developed with interdisciplinary goals and strategies to ensure resident's well-being and high quality of life. The facility policy Participation in Recreational Programs, dated 3/2023, documented residents had the right to attend and participate in recreational programs of their choice. Residents were provided with support, transportation, and assistance to attend programs as needed. Unless otherwise instructed by physician or nursing personnel, all residents would be allowed to attend all programs put on by the recreation department. Consideration for program adaptation included cognitive impairment, behavior, and preference to be in room. Resident #158 had diagnoses that included Alzheimer's disease, dementia with other behavioral disturbances, and muscle weakness. The 2/1/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had inattention and disorganized thinking, exhibited physical, verbal, and other behavioral symptoms, and required maximum assistance to total dependence for activities of daily living. The 8/3/2023 Minimum Data Set annual assessment documented the resident preferred to have snacks between meals, read books, magazines, or newspapers, listen to music, participate in their favorite activities, and do things with groups of people. The resident's comprehensive care plan, revised 6/9/2023, documented the resident had impaired cognition function due to Alzheimer's dementia. Interventions included to utilize the resident's preferred name, to face the resident when speaking to them, and ask yes or no questions. The comprehensive care plan, revised 2/5/2024, documented the resident was dependent on staff and family to meet their emotional, intellectual, physical, and social needs related to their progressing dementia. Interventions included the resident would be invited to scheduled activities, be provided a program of activities of interest, be provided with materials for individual activities such as a radio, personal harmonica, books, poetry, and opportunities for spiritual care. The resident also needed one-to-one in-room visits and activities if unable to attend out of room events. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's care instructions documented to minimize the resident's potential for disruptive behavior by diverting the resident's attention with objects to fiddle with or place the resident near the jukebox with music on. The resident's preferred activities included music, playing the harmonica, singing along to hymns during spiritual programs, listening to a specific radio station, having poetry read to them, and having friends and family visit. The 2/1/2024 unsigned activity assessment documented the resident did best in one-to-one activities as they were disruptive in group activities. The resident spent most of their day in their room listening to music, looking out the window, socialized with residents who wandered in, and visited with family and friends. The resident loved sweets and would accept a snack pass. When the resident was not disruptive, the resident was moved to the activity room for socialization and stimulation. When the resident was too disruptive in activities, they were removed from the activity area. The resident's activity records documented the resident attended three group activities in March 2024, and no group activities in April 2024. The resident had two individual activities or engagements documented in March of 2024, and four individual activities or engagements documented in April of 2024. The resident's certified nurse aide behavior monitor documented the resident had four episodes of screaming (not at others) and one episode of anxious restlessness in April 2024. The unit activity board calendar documented: - on Tuesday, April 16th there was an 11:00 AM Songs You Remember and at 2:30 PM Chair Zumba. - on Wednesday, April 17th there was a 10:00 AM Morning Movement, at 1:30 PM Easy Trivia, and at 3:30 PM Tasty Treats. The following observations were made of the resident: - on 4/15/2024 at 10:27 AM, in their room, leaning forward in a reclining wheelchair chair, facing the wall with the window behind them. Their radio was playing explicit new age rap music from a local radio station. - on 4/16/2024 at 8:25 AM, in their room yelling, leaning forward in their reclining wheelchair. They were next to the closet and not within view of the door. There was no music or TV on. At 10:50 AM, the resident was in their chair around the corner in their room, out of the sight of the door. The radio was set to a station playing quietly. - on 4/17/2024 at 8:51 AM, in their room in their reclining wheelchair, leaning forward, quiet but alert, looking around their room. They were around the corner in their room, out of sight of the door. At 9:57 AM, the resident's radio was playing loud new age rap music. The resident was leaning forward in their wheelchair, staring at the wall. At 11:05 AM, the resident was leaning forward in their wheelchair, staring at the wall, with the radio on. At 3:51 PM, the resident was singing loudly in their room with the radio off. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/2024 at 11:16 AM, the resident's family member stated the resident liked sweets and any time they brought the resident sweets they ate the entire package. The resident also liked music especially blues and jazz as the resident used to play guitar. They stated the resident did not like new age rap music. They stated they provided compact discs for the resident to listen to as well. The resident was in their room a lot and it was more for other residents since the resident got loud sometimes. They stated they would like the resident to go to more activities as they believed it would be better for the resident to get out of their room more. During an interview on 4/22/2024 at 1:11 PM, certified nurse aide #70 stated if a resident did not want to get up, they would let them stay in bed and then encourage them to get up for breakfast. They stated Resident #158 got up during the night shift and in the morning, they checked on the resident to see if they needed to be changed and then brought the resident out to a common area. They stated the resident stayed in their room a lot because they yelled. They did not like to leave the resident in their room by themselves. The resident did better in a group setting and if the resident was having a good day, they should be out with everyone. If the resident was yelling, they moved the resident away from everyone. They stated the resident probably would not like new age rap music and they usually put on the compact disc music that was in the resident's room. During an interview on 4/22/2024 at 1:17 PM, licensed practical nurse #46 stated the resident was in their room a lot because they had a lot of outbursts. When the resident was agitated, they started swearing which agitated other residents. If the resident was not having outbursts, they should be out in the common area. If the resident was agitated, they brought the resident to their room and put on music to calm them down. The resident listened to a lot of country and liked to look out the window when in their room. They also liked to participate in activities and did great in activities. The resident would not like to listen to new age rap but sometimes that was what a local radio station would play. The resident also had compact discs to play. During an interview on 4/22/2024 at 1:31 PM, licensed practical nurse Unit Manager #52 stated they were covering for the resident's current unit. They stated that while it depended on a resident's behavior, non-independently mobile residents should be brought to the common area. They stated if Resident #158 was yelling, being in their room with music calmed them down. The family brought in compact discs to put on for the resident. They stated they were unsure what type of music the resident liked. During an interview on 4/22/2024 at 1:46 PM, social worker #71 stated residents who were not independently mobile, especially if they were a fall risk, should be in a common area on the dementia unit. They stated if the resident was not exhibiting yelling behaviors, they should be in a common area. They stated staff were always trying to engage the resident and have them out of their room as much as their behaviors allowed. When the resident was agitated, being in the room with music was a good way to calm them down. The resident enjoyed listening to a specific radio station and looking out the window. A resident with dementia could have negative effects from sitting in their room with no stimulation or interaction. The resident could have a day that did not start well but once the resident was calmed and doing better, they should be engaged in activities. 10NYCRR 415.12

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	335136	A. Building B. Wing	04/23/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35045 Based on observation and interview during the recertification survey conducted 4/23/2023 -4/23/2024, the facility did not ensure drugs and biologicals were labelled and stored in accordance with currently accepted professional principles for 5 of 12 medication carts ([NAME] units 3, 4, 8, 10, and 14) reviewed, and 1 of 6 medication rooms ([NAME] unit 5) reviewed. Specifically, the medication cart on [NAME] unit 3 had nicotine patches without resident labels; [NAME] unit 4 had expired medications; [NAME] unit 8 has insulin without a labeled open date; [NAME] unit 10 had inhalers not in the correct pharmacy box and without labeled open dates and unlabeled eye medications; [NAME] unit 13 had personal food items stored with resident medications; and [NAME] 5 medication room had a refrigerator with a significant amount of ice buildup. Findings include: The facility policy Over the Counter (OTC) Medications- Floor Stock dated 4/5/2019 documented that eye drops, nasal spray, and eardrops should be obtained from the pharmacy to ensure proper resident specific labeling. Each week the Director of Nurses' designee would review supply of house stock. Newly obtained stock items would be placed in the back to ensure proper rotation and that items were used before the expiration date. The existing stock would have expiration dates checked. Any items found expired would be removed immediately. The proper disposal of expired or unused [over the counter] medications was to place them in the same place as the pharmacy medication returns. The facility policy Drug and Biological Storage: Medication Refrigerators dated 10/11/2021 documented that all injectable drugs and biologicals delivered to the facility would have pharmacy labels on the outside container as well as the drug vial, should the container and vial be separated. Once the injectable drug was opened a sticker noting the date the vial was opened and the initials of the nurse should be placed on the vial, or the information written directly on the vial. Medication Carts During an observation and interview on 4/17/2024 at 10:27 AM, [NAME] Unit 3 medication cart 1 had a nicotine 14 mg patch without a resident label. Licensed practical nurse #6 stated the nicotine patch was for a current resident but was not labeled and should have been. They stated if medications were not labeled properly, there could be an error and be given to the wrong resident. During an observation and interview on 4/17/2024 at 11:23 AM, [NAME] Unit 13 medication cart had a glazed donut stored in an opened clear plastic bag in the small second drawer under the narcotic locked box. Registered nurse Unit Manager #27 stated they looked at the cart at 6:00 AM that morning and there was not a donut stored in the medication cart. They stated the donut should not be in the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/17/2024 at 3:27 PM, [NAME] Unit 4 medication cart 1 had three bottles of expired medications: 1 stock bottle of oyster shell calcium 500 milligram labeled expired on 2/2024, 1 stock acidophilus with pectin 140 milligram bottle labeled expired 3/2024, and 1 resident specific medication citalopram hydrobromide 40 milligram, expired 11/27/2023. Licensed practical nurse #54 confirmed the 2 stock medications and 1 resident specific medication in the top drawer were expired. They stated the medication nurse was responsible for all the medications within their cart, and they should check the medications before dispensing them. During an observation and interview on 4/17/2024 at 3:30 PM, [NAME] unit 8 medication cart 1 had 2 vials of open insulin without labeled open dates, and there was no labeled pharmacy bag for the insulin vials. There was a blank sticker on the vial for the open date with the resident's name. Licensed practical nurse #73 stated the vial had been opened and belonged in a pharmacy bag with the open date on it. It was important to know the open date of the insulin because the effectiveness of the medication may be reduced after a certain amount of time. During an observation and interview on 4/17/2024 at 3:52 PM, [NAME] unit 10 medication cart 1 had 2 Trelegy Ellipta (inhaler for lung disease) without open dates. The pharmacy label documented to discard 6 weeks after opening. There was a resident specific Systane 0.4-0.3% eye gel medication and Azelastine hydrocholoride 0.1% nasal spray without labeled open dates, or expiration dates on the containers. Licensed practical nurse #74 stated all medications should be labeled with an open date. They were not sure when the 2 inhalers were opened and should be discarded due to lack of dates on the packages. The eye drops and nasal spray should have been labeled with a date open sticker and without the label they should be discarded because the medication could be expired. Medication room During an observation and interview on 4/17/2024 at 1:45 PM, the [NAME] unit 5 medication room refrigerator had significant ice buildup inside and the refrigerator temperature logbook documented the medication refrigerator should be maintained between 36-46 degrees Fahrenheit, when the temperatures were out of range: adjust thermostat, if temperature was not maintained place a high priority work order. Registered nurse Unit Manager #14 stated there was at least 6 inches of ice buildup in the refrigerator and the overnight nurse from 11:00 PM to 7:00 AM was responsible to document in the logbook and confirm appropriate temperatures were maintained. It was important to check the temperatures to ensure the medications were stored properly. During an additional observation and interview on 4/19/2024 at 9:48 AM, licensed practical nurse #13 stated that night shift was responsible for writing the refrigerator temperatures in the logbook. They stated there was about 3 inches of ice in the middle and 5 inches around the edges. They stated if the temperature check was not completed the refrigerator could have been out of range and this would affect medication storage. (continued on next page)

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	335136	A. Building B. Wing	04/23/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2024 at 1:45 PM, Assistant Director of Nursing #23 stated that once insulin was opened it should be labeled with the resident's name label and the open date. There was a little sticker that went on the vial and the pharmacy label should be on the bag where the vial of insulin would be stored. Insulin vials were specific to each resident. If there was no open date listed the insulin vial should be discarded and a new one ordered. There could be a change in effectiveness after opening a medication. The opened nasal spray should have a date on the resident sticker on the bottle, or an expiration date. If it did not have either, the medication should be discarded. The inhalers should have open dates listed, if it was not listed the medication should be discarded and a new one ordered. The inhaler inside the box should match the label on the box. If medications were not labeled and stored properly there was the potential for the resident to get the wrong medication, or an expired medication which may no longer be effective. 10 NYCRR 415.18(d) 48632 48895

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	335136	A. Building B. Wing	04/23/2024

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. 48052 Based on observation, interview, and record review during the recertification and abbreviated (NY00330471 and NY00331762) surveys conducted 4/15/2024-4/23/2024, the facility did not ensure the medical provider was promptly notified of radiology results for 1 of 1 resident (Resident #168) reviewed. Specifically, Resident #168 had x-rays ordered by the medical provider, the radiology provider reported the results to the facility, and the results were not relayed to the medical provider timely. Findings included: The facility policy Radiology Services dated 1/2024, documented radiology services would be provided to all residents in a manner that prevented errors, assured accurate communication, and provided timely ordered service and timely results to the medical provider. The nurse confirmed the order for radiology or diagnostic test in the electronic medical record and notified the technician of an x-ray/diagnostic test by calling the radiology company contracted with the facility. The radiology technician conducted the x-ray/diagnostic test and then notified the charge nurse once completed. The radiology service provided would notify the nursing unit or Nursing Supervisor for acute radiology results. All results were integrated into the electronic medical record and could be viewed in the resident's individual record on the lab/x-ray results dashboard. The nurse would notify the medical providers of the radiology results. Resident #168 had diagnoses including Alzheimer's disease, weakness, and osteoarthritis (degeneration of joints). The 10/22/2023 Minimum Data Set assessment documented the resident had severely impaired cognition and was independent with ambulation. A 12/23/2023 at 10:35 AM incident report completed by registered nurse #45, documented another resident pushed Resident #168. Resident #168 fell backwards to the ground. Resident #168 complained of pain in the left hip and knee. The resident was assisted off the floor by 2 staff into a wheelchair. The provider was called and ordered an X-ray of the left knee and hip. A physician order dated 12/23/2023 documented an x-ray for the resident's left knee and left hip for pain from a fall. The x-ray was completed on 12/23/2023. A 12/23/2023 at 2:59 PM licensed practical nurse #46 progress note documented the resident had complaints of pain to their hip and knee; an x-ray was ordered, and the supervisor was aware of the incident. The radiology results report dated 12/23/2023 documented the resident had fallen and landed on their side. Three radiographs (x-rays) were taken of the resident's pelvis and left hip at 6:03 PM. The finding was a minimally displaced fracture of the left femoral neck (where the thigh bone meets the hip) with a possible extension to the superior aspect of the lesser trochanter (hip fracture). The report was signed by the x-ray company radiologist on 12/23/2023 at 6:37 PM. The report documented the results were provided to the facility. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/23/2023 at 10:37 PM licensed practical nurse #47 progress note documented the resident's x-ray was completed and the results were pending. Nursing notes from 12/23/2023 to 12/25/2023 did not include documentation of reported x-ray results. A 12/25/2023 at 11:36 AM licensed practical nurse #48 progress note documented they were called to the floor as the resident's family member asked about the outcome of the resident's fall and pain in their left hip. Licensed practical nurse called the radiology company to obtain the results of the x-ray. The resident was observed lying on their back with a complaint of left hip pain when range of motion was attempted. Internal rotation was noted. The registered nurse Supervisor came to assess the resident. The radiology company was called again for results. The radiology company called back, and a left hip fracture was noted. The resident's family member requested the resident be sent to the hospital. The registered nurse called the provider and awaited a call back. A 12/25/2023 at 12:58 PM progress note by licensed practical nurse #48 documented the resident had been sent to the hospital for evaluation of a left hip fracture. During an interview on 4/18/2024 at 10:13 AM, Resident #168's family member stated their sibling was notified by a nurse via phone that another resident had pushed the resident over, but the resident was fine, and they were doing x-rays as a precaution. They stated their sibling called the facility three times in total to follow up on the x-rays but only received a voicemail from the nurse that assured them the resident was fine. They went to visit the resident on 12/25/2023 and the resident was lying in bed, and they thought the resident had a stroke as one side of their face was clenched tight. They got a nurse who informed them the resident did not have a stroke but had a fall. They asked the nurse about the x-rays and the nurse informed them the x-rays had not been read. They stated an hour or so later the nurse had informed them the resident had a hip fracture. During an interview on 4/22/2024 at 1:31 PM, licensed practical nurse Unit Manager #52 stated they were the covering Nurse Manager for the resident's unit when the resident was pushed over and fell in 12/2023. The resident had x-rays ordered for their left knee and left hip on 12/23/2023. They stated after an x-ray was taken nurses should follow up with the x-ray department and request the results. If an x-ray was done at 6:00 PM on 12/23/2023, they expected the nurse to follow up if the x-ray results were not reported. They stated the nurse should have followed up on the x-ray on 12/24/2023 and before the family requested on 12/25/2023. During an interview on 4/22/2024 at 2:57 PM, physician #53 stated Resident #168 fell , and the resident had an x-ray ordered. The provider group was notified of the x-ray results on 12/25/2023 after the resident was already sent to the hospital. They stated the provider group should have been notified prior to 12/25/2023 of the x-ray results. During an interview on 4/22/2024 at 3:45 PM, the Director of Nursing stated if an x-ray was abnormal, the x-ray provider would call but the report was also sent to the electronic medical record and was red under the alerts. They stated they did not have a policy on when nurses were to follow up on an x-ray, but they expected the nurses to call the x-ray company 30 to 45 minutes after an x-ray was completed if they had not heard back. They stated the x-ray should have been followed up prior to 12/25/2023 if it was taken on 12/23/2023, especially if it had not been loaded into the electronic medical record by the x-ray company. (continued on next page)

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	04/23/2024

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

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.21

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43754 Based on observation and interview during the recertification and abbreviated (NY00330555) surveys conducted 4/15/2024-4/23/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 3 test trays reviewed (4/16/2024 and 4/18/2024 lunch meals). Specifically, food was not flavorful and was not served at palatable and appetizing temperatures. Findings include: The facility policy Food Temperature Control and Correction dated 1/1/2004 documented: - Proper food temperature control and safe food practices were essential to prevent contamination or spoilage that could cause infection or poisoning. - A temperature of 41 degrees or lower was required for all entrees, meats, vegetable, cereals, eggs, starches, soups, desserts, fruits, and milks. - The Dining Service Manager was responsible to record the temperature of all foods at the start of each tray line or meal services. Trayline temperatures should be taken 1 hour from the start of the initial temperature recordings. - Protein based foods/beverages, juices, cold sandwiches, and yogurts were to be always kept in a refrigerated dispenser. During an interview on 4/15/2024 at 9:40 AM, Resident #436 stated the food does not taste good. Breakfast was the best meal, but lunch and dinner were not good. During an interview on 4/16/2024 at 11:24 AM, Director of Food Services #57 stated the meal service took about 2- 2.5 hours to complete. During an observation on 4/16/2024 at 12:55 PM, Unit 3's last tray on the cart, labeled for room [ROOM NUMBER] W, was selected to test. The tray included the following cold food items and measured temperatures: pureed coleslaw was 53 degrees Fahrenheit, pureed pasta salad was 65 degrees Fahrenheit, and the vanilla milkshake was 59 degrees Fahrenheit. The hot food items were within temperature parameters, but the fish sandwich was dried out and the fish flavor was very strong and was not palatable. During an interview on 4/16/2024 at 12:58 PM, Director of Food Services #57 stated the cold food item temperatures should be 41 degrees Fahrenheit or colder. The temperatures for the vanilla milkshake, pasta salad, and coleslaw were not acceptable. They did not do test trays very often. During an observation on 4/18/2024 at 12:22 PM, a random tray was selected on Unit 10 that was labeled for room [ROOM NUMBER]. The tray included the following cold food items and measured temperatures: juice was 54 degrees Fahrenheit, and a salad was 53 degrees Fahrenheit. These food items were not within cold food temperature parameters and did not taste palatable. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/19/2024 at 11:50 AM, diet technician #58 stated they did test trays. The test trays monitored the temperature of the food, taste, and appearance. The cold food items should be less than 41 degrees Fahrenheit. They said it was important for food to be at the correct temperature because people could get sick and the out of temperature parameter food may not be palatable. During an interview on 4/19/2024 at 12:10 PM, the Director of Clinical Nutrition stated cold food items should be less than 41 degrees Fahrenheit and food that had temperatures between 50- 60 degrees Fahrenheit was not acceptable and was not palatable. It was important for food to be served at appropriated temperatures for palatability and food safety. During an interview on 4/19/2024 at 12:16 PM, the Director of Food Services #57 stated for food safety the temperature of the cold food items should be 41 degrees Fahrenheit or below. 10NYCRR 415.14(d)(2) 49831

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43754 Based on observation, record review, and interview during the recertification survey conducted 4/15/2024-4/23/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in 4 of 14 food preparation and pantry storage areas ([NAME] Unit 4, and [NAME] Units 4, 5, 6) and in the main kitchen. Specifically, the pantry storage areas on [NAME] Unit 4, and [NAME] Units 4, 5, 6 were soiled with food spills and the refrigerators were not cleaned of food debris and spills. Additionally, the main kitchen tray line had cold food tables with food items temperatures ranging from 40- 55 degrees Fahrenheit. Findings include: The facility policy Food Temperature Control and Correction dated 1/1/2004, documented the dining services management staff were responsible for checking temperatures before food serving starts. Serving of food would not begin until all foods were at the proper cold temperature. A temperature of 45 degrees or lower was required for all entrees, meats, vegetable, cereals, eggs, starches, soups, deserts, fruits, milks, coffee, and tea. Food items that did not meet the minimum required temperatures on the tray line were pulled from the line and blast chilled. The facility Quality Control Temperature Checklist undated included mealtime, menu items to have temperature monitored with a beginning temperature, and one hour re-check of the temperature and should be initialed y the food service manager. Unclean Pantries - During an observation and interview on 4/15/24 at 2:33 PM, the [NAME] Unit 6 resident 2 door cooler in the pantry was soiled with old food spills. The Director of Housekeeping stated the housekeeping staff and Nurse Manager were responsible to keep those areas clean. - On 4/16/24 at 9:49 AM, the [NAME] Unit 5 floor pantry coolers had food spills in and under food stored in the cooler. There were multiple holes measuring half inch to 3 inches in the wall behind the retherm units. - On 4/16/24 at 10:25 AM, the [NAME] Unit 4 floor pantry refrigerator and two door cooler had food spills. The floor around and underneath the refrigerator was sticky and visibly soiled with dried food debris and spills. - On 4/16/24 at 2:25 PM, the [NAME] Unit 4 pantry refrigerator had a bottom freezer that was not in use and visibly soiled with a brown substance. Food out of temperature on the kitchen tray line: During an observation on 4/16/24 at 11:24 AM, the main kitchen tray line for was preparing for supper. The temperatures measured across the three cold tables ranged from 40 - 55 degrees Fahrenheit for diced pears and cooked chicken breast. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/16/2024 at 11:38 AM, the Food Service Supervisor stated they checked the food temperatures with a probe thermometer as the food items were removed from the cooler. They were also supposed check each food item temperature again when they had been sitting in the table. The Food Service Supervisor checked the temperature of the chicken, and the temperature was 47 degrees Fahrenheit. They stated the chicken should be below 45 degrees Fahrenheit and should be thrown out. The temperature of the chicken was not checked earlier, and they were not sure how long the chicken had not been within acceptable temperature. They measured the temperature of the pears, and they were 54 degrees Fahrenheit. They stated the pears sat out for the entire meal service which was about 4 hours. At 12:03 PM, they measured pureed burger (51 degrees Fahrenheit), pureed hot dog (54 degrees Fahrenheit), ground hot dog (54 degrees Fahrenheit.), ground chicken (65 degrees Fahrenheit), American cheese (55 degrees Fahrenheit), and pureed macaroni and cheese (48 degrees Fahrenheit). The Food Service Supervisor stated all those food items were to be used for the meal service and were not within acceptable temperature ranges. They would have come out of the cooler at 7:30 AM and had not been checked throughout the day. They stated food can be left out of temperature for four hours and then should be thrown out. At 12:09 PM, the ground hamburger was 39 degrees Fahrenheit, pureed macaroni and cheese was 47 degrees Fahrenheit, and chicken breast was 49 degrees Fahrenheit. They stated the chicken temperature was last checked around 10:00 AM that morning. 10NYCRR 415.14(h) 49831