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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification and abbreviated (NY00367212/446001) surveys conducted 8/25/2025-8/29/2025, the facility did not ensure a safe, clean, comfortable, and homelike environment for four (4) of fourteen (14) resident units ([NAME] Units 4, 5, 7, and 13) reviewed. Specifically, Resident #63 had dirty linens, and a soiled brief left at their bedside; Resident #187's room had a ceiling tile with a large brown stain and an unclean privacy curtain; Resident #314's room had a ceiling tile with a medium black stain; Resident #21's window shade had several brown spots; and Resident #373's wheelchair was unclean. Findings include:The 12/2018 Housekeeper job description documented job duties specific to housekeeping included cleaning walls and ceilings by washing, wiping, dusting, spot cleaning, disinfecting and deodorizing as instructed; and removing dirt, dust, grease, etc. from all surfaces using proper cleaning/disinfecting solutions.The facility policy “Cleaning and Disinfection/Non-critical care and shared equipment,” dated 7/22/2024 documented cleaning and disinfection of the facility, including resident rooms, was completed in accordance with environmental services policies and procedures. Privacy curtains were removed and laundered on a regular schedule, as needed, when soiled, and when a resident was removed from transmission-based precautions.The undated facility policy, “Safe and Homelike Environment,” documented the resident had the right to a safe, clean, and comfortable environment in which they received treatment and support for daily living. The facility policy “Wheelchair Cleaning,” dated 10/1/2024, documented housekeeping staff did regularly scheduled cleaning of wheelchairs. Certified nurse aides would do daily inspection and cleaning after meals as needed. Additionally, any staff member may place an electronic work order at any time if cleaning was needed outside of the routine wheelchair cleaning schedule. The certified nurse aide placed chairs to be cleaned in the designated area. To clean the chair, remove all equipment from chair (cushions, leg rests, drainage bags, oxygen canisters, and personal devices); and remove the wheelchair seat cushion cover. Both seat cover and cushion needed to be disinfected, cleaned and dried separately. The cushions and covers were placed on a designated rack for proper drying prior to being placed back on the chair. The Wheelchair Cleaning Log sheet was completed and provided to the Housekeeping Manager/Operations/Manager/Designee.Fourth Floor Observations:During an observation on 8/27/2025 at 1:49 PM, Resident #63 was lying in bed and soiled linens and a soiled brief in a mechanical lift pad were on the floor next to the bed.During a telephone interview on 8/29/2025 at 9:51 AM, Resident #63’s family stated the resident’s room frequently has soiled briefs on the floor. They saw soiled linens on the overbed table when visiting. During an interview on 8/29/2025 at 10:43 AM, Certified Nurse Aide #43 stated they provided care for Resident #63 on 8/27/2025. The resident was incontinent and was normally changed after meals. They would take the resident back to their room and change the brief while the resident was in bed. The dirty wash clothes were hung on the side of the cleaning basin and the brief was rolled up at the end of the bed. Once the resident was changed, they put the wash clothes in the dirty linen holder and the brief in the trash. They never left them on the floor as it was not (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitary.During an interview on 8/29/2025 at 11:50 AM, Licensed Practical Nurse #42 stated incontinence products and linens should never be on the floor, it was a contamination and infection control issue. They should be rolled up and put at the end of the bed and discarded before going to the next resident’s room. They had to pick up incontinence products and dirty linens before. During an interview on 8/29/2025 at 12:02 PM, Licensed Practical Nurse Assistant Nurse Manager #41 stated soiled linens and briefs should not be on the floor, they should be disposed of, and the linens should go to the soiled linens bin. During an interview on 8/29/2025 at 1:12 PM, Registered Nurse Unit Manager #48 stated soiled briefs and linens should not be left on the floor, it was unsanitary. Fifth and Seventh Floor Observations:The 6/1/2025 – 8/29/2025 work order log for the 5th floor documented maintenance exchanged ceiling tiles twice on 8/1/2025, on 8/5/2025, on 8/6/2025, and twice on 8/27/2025. Housekeeping provided a privacy curtain on 6/4/2025, and three times on 8/14/2025. During an observation on 8/25/2025 at 10:50 AM, Resident #187’s room had a brown water spot on the ceiling tile in a circular shape about the size of a dinner plate. The privacy curtain had a large brown stain at the bottom corner. During an observation and interview on 8/25/2025 at 1:31 PM, Resident #314’s room had a black stain on the ceiling tile in a circular shape about the size of a wiffle ball. The resident stated the facility changed the tile and the stain came back.During an observation on 8/25/2025 at 1:26 PM, the seventh-floor small resident lounge had a metal bed flipped on its side and parts of the bed were located throughout the room. There were multiple wheelchairs in the room. During an interview on 8/28/2025 at 11:08 AM, Housekeeping Crew Leader #58 stated they went around to the rooms and looked at the resident’s privacy curtains to see if they needed to be replaced. They changed the curtains when they were dirty. The 5th floor and below were done regularly. They kept a record for privacy curtain replacement, but the paperwork was misplaced. They stated they washed about 20 in the last couple of days. During an interview on 8/28/2025 at 3:08 PM, the Senior Director of Operations stated the small lounge was a resident area and the scattered electrical items were bed components on the floor. The repair should not have been made in a resident area. The bed and mattress should be removed from the floor and moved to the maintenance area until repaired.Thirteenth Floor Observations:The 8/2025 housekeeping logs for the 13th floor had a single line through room curtains. There was no documentation if the curtains were cleaned. During an interview on 8/26/2025 at 9:28 AM, Resident #21 stated there were several brown spots on both window shades. The resident stated they were embarrassed by them.During an observation on 8/26/2025 at 9:23 AM and 8/27/2025 at 12:44 PM, Resident #373’s navy blue wheelchair’s armrests were soiled with food particles. During an interview on 8/27/2025 at 12:49 PM, Housekeeper #60 stated they were responsible for cleaning resident wheelchairs in the morning, if they were in the hallway. There was no real schedule, night shift was doing it, but the Housekeeping Director waned them done in the morning. If the wheelchair appeared dirty, they knew to clean them. During an interview on 8/27/2025 at 12:59 PM, Certified Nurse Aide #61 stated if there was a dirty wheelchair they would clean it. Resident #373’s wheelchair armrests were dirty. They thought the night shift would have cleaned it before getting the resident up for the day. If the wheelchair was not on the schedule for cleaning that day, they would clean it when the resident went back to bed. All staff were responsible for cleaning resident chairs.During an interview on 8/28/2025 at 11:49 AM, Licensed Practical Nurse #47 stated staff should wipe down chairs if they notice them soiled. They had a schedule for each floor. Housekeeping typically cleaned chairs per the schedule and the certified nurse aides would put the chairs in the hall on the night shift. During an interview on 8/29/2025 at 12:02 PM, the Director of Maintenance stated they were made aware of the resident room ceiling tile on the 5th floor on a Friday about three weeks (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ago. They replaced it and by Monday the tile needed to be replaced again. They called the vendor for the leak and changed the tile again. There was a repair done, but it was a heating and cooling pipe, so the repair would require the system on that floor to be unable to heat or cool for approximately three hours at the minimum. The vendor had to come when the temperature was not going to be too hot outside. If housekeeping was unable to clean a window shade, they should order a new one. Once the new item came in, they notified maintenance to install the shade. They were not notified to install any window shades on the thirteenth floorDuring an interview on 8/29/2025 at 12:16 PM, the Director of Housekeeping stated staff had checklists to be completed daily for their room cleaning. Window shades were part of the deep clean, and they should be cleaned if dirty as part of the room cleaning. If the housekeeper was unable to get them clean, they should report it to the crew leader or them and they would attempt to clean it with something different. If they still were not clean, they would contact maintenance to have them replaced. They stated they were not notified of any additional cleaning needed or replacements for the thirteenth floor. The process for cleaning wheelchairs was on the 3rd shift schedule. They had a staff member that worked 4 days a week to clean chairs. Rooms assigned a deep clean got wheelchair cleaning also. If staff saw a dirty chair, they were expected to clean it when they saw it. 10 NYCRR 415.29(j)(1)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews during the recertification survey conducted 8/25/2025 - 8/29/2025, the facility did not ensure the resident environment remained free of accident hazards for three (3) of three (3) residents (Residents #5, #63, and #510) reviewed. Specifically, Residents #5, #63, and #510 were transferred via a mechanical lift with assistance of one and not assistance of two as planned.Findings includeThe facility policy Transferring Residents with Assistive Devices, dated 4/1/2024 documented Physical and Occupational Therapy were responsible for evaluating the resident and updating the activities of daily living care plan for levels of assistance and transfer status. The mechanical total lift required assist of one of two staff to operate the lift and to assist the resident, per the plan of care. Certified staff were NOT able to make a determination to use a lesser mode of transfer (ex. resident was a total mechanical lift and staff decided to use a stand/pivot transfer). Certified staff were able to make a determination to use a higher mode of transfer (ex. Resident was a sit-to-stand lift and staff decided to use a total mechanical lift). For additional information, follow the manufactures recommendations. 1) Resident #5 had diagnoses of stroke, diabetes, and surgical after care. The 7/4/2025 Minimum Data Set assessment documented the resident was severely cognitively impaired and was dependent on staff for chair to bed transfers. The Comprehensive Care Plan initiated 10/27/2023 and revised 3/12/2025 documented the resident had an activities of daily living self-care performance deficit related to generalized weakness. Interventions included chair to bed transfers with assistance of two and mechanical lift. The comprehensive care plan initiated 10/27/2023 documented the resident had risk for falls related to stroke and impaired mobility. Interventions included the use of assistive devices per physical and occupational therapy evaluations. Certified Nurse Aide #23 documented in the 8/2025 Certified Nurse Aide Activities of Daily Living Report Resident #5 was dependent, where the helper did all the effort, resident did provide the effort to complete the activity, and the assistance of two or more helpers was required for the resident to complete the activity for chair/bed-to-chair transfer on 8/28/2025. During an observation and interview on 8/28/2025 at 2:45 PM, Certified Nurse Aide #23 transferred Resident #5 back to bed from their wheelchair with a mechanical lift without additional staff assistance. Certified Nurse Aide #23 stated the mechanical lift should be used with two people, but they did not have enough staff to do that. They stated they had to do what they had to do for the residents. During an interview on 8/29/2025 at 1:23 PM, Licensed Practical Nurse #24 stated the facility policy was to use two people for a mechanical lift transfer. Resident #5 required assistance with the mechanical lift and required two people. The purpose of two people when operating the mechanical lift was for the safety of the resident. If they were moving the lift and the wheel or arm caught on the bed or anything, the resident could swing, and the lift could tip over. During an interview on 8/29/2025 at 1:37 PM, Registered Nurse Unit Manager #25 stated therapy decided whether a resident needed one or two person assistance with the mechanical lift. Resident #5 required two person assistance with the mechanical lift. Therapy decided they required two people, and they should never be assisted with only one person. Staff should read and follow the care plan for (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	each resident. Short staffing was not an excuse for inappropriate use of the mechanical lift. The unit had appropriate staffing, and everyone was willing to help, they were not short staffed on the unit. 2) Resident #63 had diagnoses including weakness, reduced mobility, and need for assistance with personal care. The 6/26/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment and was dependent for transfers. The Comprehensive Care Plan initiated 6/15/2021 and revised 4/5/2022 documented the resident had an activity of daily living self-care deficit performance related to confusion, dementia, and impaired balance. Interventions included the resident was dependent on assistance of two with the mechanical lift for transfers. The 10/17/2024 Physical Therapist #49 evaluation documented the resident required total dependence of two for transfers with the use of a mechanical lift. During an observation on 8/28/2025 from 1:39 PM-1:42 PM, Certified Nurse Aide #43 entered the resident's room with a mechanical lift. The resident was in their high back wheelchair in the room. There were no other staff present in the room. At 1:42 PM, Certified Nurse Aide #43 came out of the room with the white mechanical lift pad, the mechanical lift was still in the room and the resident was now lying in their bed. During an interview on 8/29/2025 at 10:43 AM, Certified Nurse Aide #43 stated the resident went back to bed after meals. The resident required assistance of two with the mechanical lift. They stated they transferred the resident back to bed by themselves yesterday after lunch. They were short staffed a lot and they often transferred residents by themselves even if they were supposed to be transferred with assistance of two. The resident was dead weight and was heavier and that was why they required assistance of two. During an interview on 8/29/2025 at 11:50 AM, Licensed Practical Nurse #42 stated the Kardex (care instructions) informed the certified nurse aides the resident's transfer status. If a resident was an assist of two, it was for safety or what was assessed by therapy. Resident #63 was heavy, so they required assistance of two with the mechanical lift. It was easier to position the resident in the pad and/or the chair correctly with two people. 3) Resident #510 had diagnoses including stroke with left sided weakness, abnormalities of gait and mobility, and need for assistance with personal care. The 7/31/2025 Minimum Data Set assessment documented the resident was cognitively intact and was dependent for transfers. The Comprehensive Care Plan initiated 1/10/2025 and revised 1/22/2025 documented the resident had an activities of daily living self-care performance deficit related to generalized deconditioning, impaired mobility, and weakness. Interventions included the resident was dependent on two for transfers with the mechanical lift. The 3/28/2025 Physical Therapist #50 discharge summary documented the resident was dependent for transfers. The discharge summary did not specify the use of a mechanical lift or how many staff were required for assistance. During an observation on 8/25/2025 from 11:12 AM-11:22 AM, Certified Nurse Aide #51 entered the resident's room with a mechanical lift. There were no other staff present in the room. The resident was sitting up in their high back wheelchair in a hospital gown. At 11:22 AM, Certified Nurse Aide #51 exited the room, the mechanical lift was still in the room and the resident was lying in their bed. During an interview on 8/28/2025 at 9:36 AM, Resident #510 stated they had a stroke, and staff used a mechanical lift to transfer them. They stated it was always just one staff that performed the transfer. During an interview on 8/29/2025 at 11:05 AM, Certified Nurse Aide #51 stated the Kardex informed them if a resident required one or two staff with the use of the mechanical lift. They referenced the Kardex every morning because things changed. They were a float, so they moved units a lot and was not familiar with the residents. They stated they could not recall how they transferred Resident #510 on 8/25/2025 but they would never transfer a resident alone if they required assistance of two because that could cause an accident. During a telephone interview on 8/29/2025 at 1:12 PM, Registered Nurse Unit Manager #48 stated the resident's transfer status was on the Kardex and they expected the certified nurse aides to check this daily. It was a discussion between therapy and nursing that determined if a resident required assistance of one or two with the mechanical lift. Resident #63 required two for transfers. They did not have access to the electronic medical record but thought Resident #510 required assistance of two with the mechanical lift. (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/2025 at 2:22 PM, the Director of Rehabilitation stated the expectation for mechanical lift use was staff followed the residents' care plan. The care plan documented if the resident required assistance of one or two. Therapy decided on the transfer ability and the equipment used to transfer the residents' safely. They worked with the residents and reviewed the residents' behavior, size, cognition, and diagnoses, among several additional factors that determined the residents' needs for mechanical lift transfers. If a resident was care planned for two person assist, the staff should not use just one person. The determination for the use of two was made for a reason and they needed to use two for the safety of both the residents and the employees.10NYCRR 415.12(h)(1)(2)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observations, record review, and interviews during the recertification survey conducted 8/25/2025-8/29/2025, the facility did not ensure drugs and biologicals were stored in accordance with currently accepted professional standards for four (4) of thirteen (13) medication carts (4th floor cart [NAME] building, and 5th, 7th,and 6th floor [NAME] carts), two (2) of fourteen (14) treatment carts (2nd and 4th floor [NAME] carts) and one (1) of seven (7) medication storage rooms (5th floor [NAME] medication room). Specifically, the 5th and 7th floor [NAME] medication cart had undated and expired medications and biologicals; the 6th floor [NAME] medication cart was left unattended and unlocked; the 2nd and 4th floor [NAME] treatment carts were unlocked; and the 5th floor [NAME] medication room had expired medication. Findings include:The facility policy Drug and Biological Storage of Medications, dated 5/28/2024, documented medication carts and medication supplies were locked when they were not attended by persons with authorized access. All injectable drugs and biologicals delivered to the facility would have pharmacy labels on the outside container as well as the drug vial should container and vial become separated. Once an 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 could have been written directly on the vial. Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures were immediately removed from inventory, disposed of, and reordered from the pharmacy if a current order existed. Unsecured Treatment Cart: During an observation on 8/25/2025 from 12:26 PM to 12:36 PM, the treatment cart on 2 [NAME] located outside room [ROOM NUMBER] was unlocked and contained intravenous supplies and scissors. At 12:36 PM an unidentified staff walked by and locked the cart. During an observation on 8/27/2025 at 11:48 AM, the treatment cart on 2 [NAME] was unlocked. The top drawer contained two pairs of scissors, Aspercream (topical pain relief), bacitracin, triple antibiotic ointment, silver antimicrobial wound gel, itch relief cream, and Medi honey (wound treatment). The second drawer contained bottles of barrier cream, zinc oxide, and xeroform (wound dressing). The third drawer contained gauze and varied dressing supplies. During an observation on 8/28/2025 at 8:55 AM the treatment cart on 4 [NAME] was unlocked and in the hallway. During an interview on 8/27/2025 at 12:46 PM, Licensed Practical Nurse #8 stated they were responsible for passing medications. The treatment cart and medication cart should be locked and tethered when unattended and the screen on the medication cart had to be in the off position. When they left the medication cart, they made sure it was locked and tethered to the wall for safety reasons. During an interview on 8/28/2025 at 9:10 AM, Registered Nurse Unit Manager #4 stated they expected medication and treatment carts to be locked when unattended for the safety of residents. Both carts contained medications that could be dangerous for residents. (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Unsecured Medication Cart: During an observation on 8/26/2025 from12:18 PM to 1:15 PM, the 6th floor [NAME] medication cart was unlocked and unattended near the dining room doorway. During an interview on 8/28/2025 at 10:20 AM, Licensed Practical Nurse #20 stated medication carts should be locked when not in use. The nurse assigned to the cart was responsible for ensuring the cart was locked when they walked away. The unit had wandering residents who took things. They did not recall the medication cart being unlocked during the lunch meal on 8/26/2025 but they could have been distracted or called into the dining room. During an interview on 8/28/2025 at 11:05 AM, Registered Nurse Unit Manager #21 stated medication carts should be locked whenever the nurse was not actively accessing medications. They had wandering and confused residents on the unit that attempted to take things from unauthorized places. During an interview on 8/29/2025 at 3:08 PM, the Director of Nursing stated medication carts should be kept locked when the nurse was not near the cart. Each cart had its own set of keys, and they were kept with the assigned nurse. The carts were kept locked to avoid residents or anyone else from getting into them. Improper Storage and Labeling of Medication: During a 5th floor Cunninham medication cart observation on 8/27/2025 at 12:17 PM with Licensed Practical Nurse #22, the following was observed: -1 opened bottle of ferrous gluconate (iron supplement) 324 milligram tablets with a manufacturer's expiration date of 6/30/2025. -1 opened bottle of Vitamin D 25 microgram tablets with a manufacturer's expiration date of 7/2025. -2 bottles of Atropine sulfate 1% ophthalmic solution (medicated eye drops) with a handwritten date of 5/10 and 5/8. -2 bottle of artificial tears with no open date -3 Trelegy inhalers, 2 Symbicort inhalers, 1 albuterol inhaler, 2 Fluticasone inhalers, 1 Incruse Ellipta inhaler, and 1 Breo Ellipta inhaler with no open date documented or had expired. During a 7th floor [NAME] medication cart observation on 8/27/2025 at 12:48 PM with Licensed Practical Nurse #53, the following was observed: -2 bottles of dry eye relief dated as opened 6/10/2025 and 7/9/2025. -Olopatadine 0.1% eye drops (medicated eye drops) opened 6/6/2025 -Systane dry eye drops opened 5/13/2025 - 1 Bevespi inhaler opened 5/2/2025 and 1 opened 6/24/2025 (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1 Anoro ellipta inhaler and 3 Trelegy inhalers not dated when opened -1 Anoro ellipta inhaler opened 7/9/2025 with packaging documented discard after six weeks During an interview on 8/27/2025 at 12:48 PM Licensed Practical Nurse #53 stated eye drops were good for 28 to 30 days after opened. The eye drops noted above were all expired. They arrived after the start of the morning shift and some of the medications were administered before they arrived. Inhalers were dated when opened and some discarded in 7 days, some 28 days, it depended on the medication. They administered inhalers from the cart, noticed they were not dated, and ordered new inhalers. They worked different floors and tried to get the medications administered and if they were expired or not dated, they tossed them out and ordered new ones from the pharmacy. During an interview at 8/28/2025 at 4:35 PM Registered Nurse Supervisor #55 stated eye drops should be labeled when opened. The expiration date depended on the medication but could be 14 days and expired based on the facility policy. They should be labeled when opened so the nurse knew how long they were good for. Inhalers should be labeled when opened and expired based on the pharmacy discard timeframe or per facility policy. They expected the nurses to go through the cart routinely to make sure eye drops and inhalers were labeled and discarded when expired. During an interview on 8/28/2025 at 4:46 PM, Registered Nurse Unit Manager #54 stated they expected eye drops to be labeled when opened and they expired 30 days after being opened. They had to be dated so staff would know when they expired. They expected inhalers to be labeled when opened and the expiration date depended on the inhaler. Inhalers needed to be labeled for infection control reasons and so staff knew when they should be discarded. The carts should be looked at daily for any expired medications by the nurse assigned to the medication cart. Expiration dates should be verified before administering any medication. Unlocked medication cart screens During an observation on 8/27/2025 at 11:53 AM the 4th Floor [NAME] team 4 medication cart had a computer screen with multiple resident names on the screen across from the dining room where several residents were sitting waiting for lunch. During an interview on 8/27/2025 at 12:46 PM, Licensed Practical Nurse #8 stated they were responsible for passing medications. The treatment cart and medication cart had to be locked and tethered when unattended and the screen on the medication cart had to be in the off position. When they left the medication cart, they made sure it was locked and tethered to the wall for safety reasons, and the screen was in the off position to ensure privacy for all residents. They forgot to put the screen on the off position today. During an interview on 8/28/2025 at 9:10 AM, Registered Nurse Unit Manager #4 stated they expected the resident information screen on the medication cart to be in the locked position when not being used so residents did not have access to other resident's confidential information. 10NYCRR 415.18(d) .

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observations, record review, and interviews during the recertification and abbreviated (NY002586082/iQIES 446001) surveys conducted 8/25/2025-8/29/2025, the facility did not ensure food was served at palatable and appetizing temperatures in accordance with professional standards for food service for 9 anonymous residents and 2 of 2 test trays (8/27/2025 and 8/28/2025 lunch meals) reviewed. Specifically, the lunch meal test trays on 8/27/2025 and 8/28/2025 were not flavorful or served at palatable and appetizing temperatures; and 9 anonymous residents at the Resident Council Meeting stated the food was often cold, not flavorful, and overcooked. Findings: The facility policy Resident Meals, dated 1/2020, documented each resident received meals that were nourishing and palatable. Food and nutrition staff would monitor and audit food trays, so they were palatable, attractive, and served at a safe and appetizing temperature. A new tray would be issued if it was not. The undated facility policy Tray Service to Residents, documented the Dining Services Department would ensure food carts were docked on each floor at scheduled times. Test Trays were to be performed monthly. Nursing Services was to open the cart doors once the retherm (food reheating) cycle was completed. Trays were then delivered to the residents. During a resident council meeting on 8/26/2025 at 10:00 AM, 9 anonymous residents stated the food was usually cold, overcooked, and not palatable. During a meal observation on 8/27/2025 at 12:26 PM, Resident #528 stated they would not eat the meal as it did not look appetizing and looked overcooked on one side. The tray was tested for temperature and palatability with the following results: -roasted seasoned potato was 148 degrees Fahrenheit and had no flavor.-wax beans were bland.-pot roast was 126 degrees Fahrenheit, looked dry, and was dark brown on one side. -soup was 145.8 degrees Fahrenheit and had no flavor.-juice in a small plastic container was 61.7 degrees Fahrenheit.-gelatin with fruit was 52.5 degrees Fahrenheit. During a meal observation on 8/28/2025 at 12:11 PM, Resident #470's tray was used as a test tray, and a replacement was requested. The tray was tested for temperature and palatability with the following results: -soup was 153.9 degrees Fahrenheit and tasted bland.-hamburger was 143.3 degrees Fahrenheit and tasted warm.-potato salad was 50.9 degrees Fahrenheit.-coffee was 139.1 degrees Fahrenheit.-cranberry juice was 55.2 degrees Fahrenheit and tasted warm. During an interview on 8/27/2025 at 12:46 PM, Licensed Practical Nurse #8 stated residents had stated the food did not taste good. The nurse would then ask for an alternate from the kitchen. One resident told them the meat was just a hamburger in a pool of grease, and the resident was offered some soup. The units usually had the supplies to make a resident a peanut butter and jelly sandwich as a replacement. The kitchen prepared the food portions of the meal tray and unit staff prepared drinks separately. During an interview on 8/27/2025 at 1:37 PM, Certified Nurse Aide #28 stated they used to work in food service in the past. They were aware residents complained about the food being cold and not liking the consistency. The food looked overcooked and dry many times in the past. During an interview on 8/28/2025 at 9:10 AM, Registered Nurse Manager #4 stated they received frequent resident complaints about food. The complaints included the trays taking too long to get to the unit, the food being cold, and items missing from the trays. The residents' meal trays were set up in the kitchen by dietary staff. During an interview on 8/29/2025 at 12:45 PM, Dietary Aide #29 stated they prepared resident foods and brought the meal trays to the units. The cooks tasted the food while cooking. Food temperatures should be cold items below 40 degrees Fahrenheit and hot items above 140 degrees Fahrenheit. The food should be flavorful. During an interview on 8/29/2025 at 12:52 PM, Food Service Supervisor #30 stated tray audits were done on a daily and random basis and were documented. Audits included palatability. Test trays were done to ensure proper food temperature, palatability, and presentation. Cooking was done in the commissary and kitchen staff only plated the food. If the food did not look the way it should, kitchen staff should make the Director of the Commissary aware. They stated the acquired test tray temperatures were out of range. Soups were made on the units and that may be why they tasted bland. During an (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 8/29/2025 at 1:09 PM, Commissary Director #14 stated they made the food, including the entrees, starches, eggs, and cereal. They also prepared the different consistencies. The food was cooked in the commissary, and the cooks should taste the food. Each meal was cooked 5 days in advance. The pot roast should have some liquid in the pan to keep it moist. The roast was precooked from a vendor and only sliced by the facility. Once the food was sent to the tray line and plated, the trays were placed on a cart, the cart was sent to the assigned unit, and the carts were placed in a machine to warm/heat the food. Each cart was placed in a machine, and the warming timer was set by dietary staff. The temperature differences may have been due to the food positioning on the plate. 10NYCRR 415.14(d)(1)(2)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observations, record review, and interviews during the recertification survey conducted 8/25/2025-8/29/2025, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety for two (2) of two (2) kitchens (basement and second floor main kitchens), and four (4) of fourteen (14) kitchenettes ([NAME] 13, [NAME] 2, 3, and 4 kitchenettes) reviewed. Specifically, the basement and second floor kitchens had unclean areas, standing water, and appliances in disrepair; [NAME] 3 kitchenette had expired food; [NAME] 2 kitchenette had expired food and undated foods; [NAME] 4 kitchenette had expired food; and [NAME] 13 kitchenette had out of range refrigerator temperature and food, and incomplete temperature logs. Findings include:The undated facility policy Pantry / Freezer Temperature Control, documented it was necessary to monitor the temperatures of the pantry coolers and freezers regularly in order to insure that the food items served to the residents were kept at acceptable temperature levels; a maintenance staff member would check and record the temperature of every pantry cooler and freezer on each floor of the [NAME] and [NAME] buildings daily; and during the remainder of the day, nursing staff would monitor for any changes in temperature and report to a kitchen manager if temperature was above 45 degrees Fahrenheit. Expired food:During an observation on 8/25/2025 at 2:14 the [NAME] 3rd floor kitchenette had two loaves of bread with expiration dates of 7/25/2025 and 8/21/2025 and one loaf of bread with green growth on it. During an observation on 8/25/2025 at 3:12 the [NAME] 2nd floor kitchen had brown bananas and a loaf of bread with an expiration date of 8/2/2025.During an observation on 8/26/2025 at 9:50 AM, the [NAME] 2nd floor kitchenette had one brown banana, two undated turkey subs in the refrigerator, a loaf of bread with an expiration date of 8/2/2025, and one loaf of gluten free bread with no expiration date. During an observation on 8/26/2025 at 9:56 AM the [NAME] 4th floor kitchenette had a breakfast muffin dated 8/13/2025. During an observation on 8/26/2025 at 10:30 AM, the [NAME] 3rd floor kitchenette had two loaves of bread with expiration dates of 7/17/2025; three loaves with an expiration date of 8/23/2025; one loaf with an expiration date of 8/25/2025; and one loaf with an expiration date of 8/21/2025.During an interview on 8/27/2025 at 12:46 PM, Licensed Practical Nurse #8 stated the kitchen stocked the kitchenette with bread and made sure food was not expired. During an interview on 8/27/2025 1:58 PM, Food Service Aide #62 stated they checked for expiration dates, but normally no one else did. The person that brought the bread to the unit was supposed to check the bread before they stocked it. The bananas were too ripe. Expired food including bread and bananas should be thrown out. They were not sure why the bread and bananas were not discarded.Refrigerator Temperatures:The [NAME] Unit 13's cooler/freezer log documented temperatures of 45 degrees Fahrenheit or higher 4 out of 29 days in June 2025;16 out of 30 days in July 2025; and 3 out of 26 documented days in August 2025. Additionally, one day in July 2025 had no documented temperature.During an observation on 8/26/2025 at 4:42 PM, the 13th floor main refrigerator thermometer read 62 degrees Fahrenheit, the surveyor's thermometer read 66 degrees Fahrenheit, and the facility thermometer read 65 degrees Fahrenheit.During an observation on 8/26/2025 at 4:51 PM, the 13th floor refrigerator had four egg salad sandwiches measuring 54 degrees Fahrenheit, and one Magic Cup (frozen nutritional supplement) measuring 56 degrees Fahrenheit. The temperature form for August 2025 had three temperatures of 48 degrees Fahrenheit. During an interview on 8/28/2025 at 10:03 AM, the Food Service Director stated maintenance staff documented the daily temperatures of the kitchenette coolers but was not sure who was responsible for ensuring cold food items were maintained under 41 degrees Fahrenheit. Cold food items were brought up to the units at 41 degrees Fahrenheit or lower. They were not sure why the egg salad sandwiches were in this refrigerator, as it was not common practice to take sandwiches off the food cart and place them into a kitchenette after food service (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was done. A 54-degree Fahrenheit egg salad sandwich was not acceptable. During an interview on 8/28/2025 at 3:32 PM, the Director of Maintenance stated Maintenance was responsible for testing the air temperatures within the unit refrigerators. Cold food items were supposed to be held between 35 and 41 degrees Fahrenheit. The temperatures of the egg salad and the Magic Cup on the 13th floor were not acceptable. Usually, they reviewed the unit temperature sheets once a month, and if an air temperature was high, they should contact the food service management staff and ask them to take a temperature of a food item in the specific refrigerator and then take it again 15 to 20 minutes later to ensure the refrigerator was working. During an interview on 8/28/2025 at 12:08 PM the Commissary Director stated the commissary kitchen prepared egg salad, and the basement kitchen staff made the egg salad sandwich in the basement kitchen. It was not in their scope of responsibility to check kitchenette refrigerators. The proper cold holding temperature range was 34 to 41 degrees Fahrenheit and a 54-degree Fahrenheit egg salad sandwich was not acceptable.Kitchen Cleanliness:The following observations were made in the basement and second floor kitchens:-on 8/25/2025 between 10:00 AM and 11:00 AM, there was approximately 0.5- 1.0 inch of standing water on the floor where staff were plating food-on 8/26/2025 at 4:16 PM, 12 ceiling tiles had food debris on them. -on 8/26/2025 at 4:27 PM, the second-floor kitchen had duct tape on the milk and juice cooler doors.-on 8/27/2025 at 3:33 PM, there was standing water throughout the main kitchen floor, especially near where food was being plated.-on 8/27/2025 at 3:36 PM, the basement kitchen dish machine was not working or moving and was not clean.-on 8/28/2025 at 10:08 AM, the basement kitchen dish machine contained a large amount of food debris.During an interview on 8/28/2025 at 10:03 AM, the Food Service Director stated they were waiting for conveyor repairs that loaded to the dish machine area. Water was supposed to be fed continuously onto the plates as they were being scraped on the dirty side of dish machine. That was an ongoing issue for a few months. Part of the general closing process was to scrape out any solid foods from the smaller drain area. They were not sure where the water on the floor around the tray line area in the basement kitchen was coming from and it should be cleaned/squeegeed to the nearest drain. Ceiling tiles were cleaned as needed and they were not aware of the stained ceiling tiles and grid in front of the dish machine. They were not sure if any work orders were made for the three chest coolers or how long the duct tape had been on those coolers. During an interview on 8/28/2025 at 3:32 PM, the Director of Maintenance stated they were not aware of milk crate cooler doors being held open by duct tape and had not received any related work orders. Duct tape was not a cleanable surface. Kitchen staff were responsible for cleaning ceiling tiles in the basement kitchen, and the Food Service Director should make sure it was done. The floor should be squeegeed throughout the day by any kitchen staff and standing water was not acceptable. Staff were supposed to lift the conveyor belt and rollers over the trough and fully clean it out every night before they left. 10NYCRR 415.14(h)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey conducted 8/25/2025-8/29/2025, the facility did not maintain an effective pest control program so that the facility was free of pests for seven areas (the basement and 2nd floor kitchen, and [NAME] units 3, 5, 6, 8, and 10. Specifically, pest control was not maintained for fruit flies in the basement and 2nd floor kitchen, and [NAME] units 3, 5, 6, 8, and 10.Findings include:The facility policy Pest Control Program, revised 10/5/2017, documented the facility would maintain an on-going pest control program to ensure the building was kept free of insects and rodents. The undated pest sighting/evidence log documented fruit flies/gnats were found throughout the facility between 6/6/2025 and 8/7/2025. The pest control vendor service invoices documented small flies were found throughout the facility from 5/31/2025-8/26/2025. The causes included trash in garbage cans, unclean floor drains, food debris in the dish machine, The following observations of flying insects were made: -On 8/25/2025 between 10:00AM AM and 11:00 AM in the basement and second floor kitchens. -On 8/25/2025 at 1:51PM on 6C near the kitchen elevator. -On 8/26/2025 at 9:17 AM on 8C near the dining room, in front of room [ROOM NUMBER]; at 9:22 AM at the end of the hall near rooms 818-820; at 11:57 AM in the dining room with residents present and staff preparing tables for lunch. -On 8/26/2025 at 10:18 AM in the second-floor kitchen. -On 8/27/2025 at 12:30 PM throughout the second-floor kitchen. -On 8/27/2025 at 1:37 PM in the 10C kitchenette. -On 8/28/2025 at 9:44 AM on 5C in the back of the dining room during the breakfast meal; at 11:20 AM in the hallway across from room [ROOM NUMBER]. -On 8/28/2025 at 10:17 AM in the 10C television room. -On 8/29/2025 at 8:30 AM on 3C in the hallway near room [ROOM NUMBER]. -On 8/29/2025 at 9:22 AM on 8C in the elevator lobby. During an interview on 8/28/2025 at 10:03 AM the Food Service Director stated they were waiting for conveyor repairs to the dish machine area and water was supposed to be fed continuously onto the plates as they were being scraped on the dirty side of the dish machine. This dish machine issue did not help with the fruit flies. The tray line area should be cleaned/squeegeed to the nearest drain. The standing water did not help with the effort to eliminate fruit flies from the facility. Fruit flies were present on the units and basement kitchen for a few months. A vendor came weekly and fogged the (continued on next page)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchen. During an interview on 8/28/2025 at 12:08 PM, the Commissary Director stated there had been fruit flies in the second-floor kitchen since mid-summer. During an interview on 8/28/2025 at 3:32 PM, the Director of Maintenance stated overall, the amount of fruit flies had decreased in the two kitchens throughout the facility, and there was communication on the resident floors to run the water down the drains with chemicals to keep them clear. During an interview on 8/29/2025 at 8:47 AM Housekeeper #17 stated there was an abundance of fruit flies everywhere. During an observation and interview on 8/29/2025 at 9:20 AM, Licensed Practical Nurse #18 stated if they saw pests they tried to take a picture of if or capture it and let housekeeping know about it. As they were speaking a small flying insect circled the top of the medication cart. They stated the insect had been following them all morning with the sweets (applesauce) on their cart. During an interview on 8/29/2025 at 9:28 AM Unit Manager #52 stated pest control was a problem, they were everywhere, and it was annoying to swat at them all the time. During an interview on 8/29/2025 at 12:16 PM the Director of Housekeeping stated they were notified of fruit flies and saw fruit flies in the building. The pest control vendor came every Tuesday and whenever needed. 10NYCRR 415.29(j)(5)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interviews during the recertification and abbreviated (NY00375455/iQIES 446000) surveys conducted 8/25/2025-8/29/2025 the facility did not ensure allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated to prevent further potential abuse and mistreatment for one (1) of eight (8) residents (Resident #50) reviewed. Specifically, Resident #50 sustained injuries of unknown origin with unexplained bruising to the head, shoulder, and upper chest that was not thoroughly investigated to rule out abuse or mistreatment. Additionally, the resident's injuries of unknown origin were not reported to the New York State Department of Health within 24 hours as required. Findings include: The facility policy Adverse Incidents and Incident Reports, dated 10/21/2024, documented an injury of unknown origin was an injury with no known incident of origin and after investigating, abuse or care plan violation could not be ruled out. Injuries of unknown origin were reported to the Assistant Director of Nursing, the Director of Nursing, and the Administrator. The Administrative staff followed on-line reporting procedures and notified the Department of Health as the internal investigation was being conducted. The New York State Department of Health Nursing Home Incident Reporting Manual dated 8/2016 documented an injury of unknown origin was when both of the following conditions were met:-The source of the injury was not observed by any person and the source of the injury could not be explained by the resident.-The injury was suspicious because of the extent or location of the injury, or the number of injuries observed at one particular point in time, or incidences of injuries over time. The following two elements must be present for an incident to be reportable to the New York State Department of Health:-Injury without known incident.-The facility was unable to rule out abuse of care plan violations.Incidents resulting in serious bodily injury must be reported within two hours after forming a suspicion; all other incidents must be reported within 24 hours. Resident #50 had diagnoses including dementia and osteoporosis (weak, fragile bones). There was no documented diagnosis of thrombocytopenia (a medical condition which may cause increased bruising/ bleeding). The 3/6/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not have behavioral symptoms, did not exhibit wandering, and required supervision for walking and transfers. Interventions included in the event of a fall monitor/document/report as needed to physician pain or bruises. The Comprehensive Care Plan initiated 9/17/2024 and revised 3/27/2025 documented the resident had a right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Interventions included all staff would immediately report to their supervisors any suspected or witnessed incidents of abuse. The resident was at risk for falls related to poor safety awareness. The 3/11/2025 at 8:41 AM Licensed Practical Nurse Unit Manager #33 incident note documented bruising was noted by staff to the resident's right shoulder and right chest while providing morning care. Range of motion was at baseline for the resident and pictures were uploaded for weekly monitoring. There were no signs of pain or discomfort noted but they would administer as needed Tylenol due to the resident's inability to verbalize discomfort. An investigation was initiated. There was no documented evidence the resident was assessed by a registered nurse when the bruising was discovered. The 3/11/2025 Investigation Report completed by Licensed Practical Nurse Unit Manager #33 documented:- at 8:30 AM, bruising was noted to the resident's right shoulder and the right chest by staff while providing morning care. The resident's son was on the unit to wash the resident's hair and brought an area of bruising on the resident's right top of head, above their ear and towards their forehead to Licensed Practical Nurse Unit Manager #33's attention. -The investigation conclusion was obtained through staff statements and interviews and information in the chart. -The Certified Nurse Aide #34 statement for the investigation of injuries of unknown origin documented they were assigned the resident, the incident was unwitnessed, and they noticed the bruising during morning care. There were no patterns of activities or behaviors that could have contributed to the incident.-The Certified Nurse Aide #35 statement for the investigation of injuries of unknown origin documented they were not assigned the (continued on next page)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, and they did not witness the incident. The resident was unsteady on their feet and could have walked into the wall. -Certified Nurse Aides #36, #37, and #38 statements documented they were not assigned the resident, and they did not witness the incident. There were no patterns of activities or any behaviors that could have contributed to the incident. It was unknown if anyone else was involved in the incident. -The investigation conclusion documented the residents ambulated around the unit independently and the resident could have accidently bumped self on the edges of the doors while ambulating due to poor safety awareness. It was reasonable to say that no abuse, neglect, or mistreatment took place, all care plan interventions were in place, and no policy and procedure violations were noted. There was documented evidence how abuse, neglect, or mistreatment was ruled out with bruising to multiple areas on the resident's body. A 3/11/2025 at 8:53 AM Licensed Practical Nurse #33 progress note documented the resident was observed scratching their face which left bruising with small scratches along the left jaw line. The physician assistant and family were made aware. The 3/11/2025 Skin and Wound Evaluation documented the following new wounds:-Bruise to right lateral front scalp measuring 16 centimeters squared; 7.6 centimeters long by 2.8 centimeters wide.-Bruise to right chest measuring 60 centimeters squared; 14.3 centimeters long by 6.8 centimeters wide.-Bruise to right shoulder measuring 40 centimeters squared; 10.4 centimeters long by 5 centimeters wide.-Bruise to left jaw measuring 1.4 centimeters squared; 3.7 centimeters long by 1.3 centimeters wide.The 3/12/2025 Physician Assistant #32 acute visit progress note documented they were asked by nursing staff to evaluate the patient today due to multiple new areas of ecchymosis (bruising). Per nursing staff ecchymosis of the right shoulder and right chest increased and the patient seemed to be uncomfortable today. There was no documented fall or injury per the Nurse Manager. The Nurse Manager was suspicious the resident may have walked into a doorway. Per nursing staff, the resident's mentation was at baseline. Nursing staff had no further behavioral or symptomology concerns at the time of the assessment. They were unable to obtain a review of symptoms from the patient's own statement due to cognitive impairment. On exam, there was diffuse ecchymosis across the right anterior chest, anterior shoulder and posterior aspects of the shoulder. Tenderness was noted to the anterior shoulder and clavicular. Range of motion was guarded in all planes. The 3/12/2025 right shoulder radiology report (X-ray) documented a nondisplaced incompletely healed right lateral clavicular (collarbone) fracture. There was no documented evidence the resident's unexplained bruising to the head, shoulder, and upper chest, and was reported to the New York State Department of Health within 24 hours as required. The 3/13/2025 Licensed Practical Nurse Unit Manger #33 progress note documented x-ray results were discussed with the resident's daughter; they were made aware of the sentinel event investigation, the therapy evaluation requests, and pain control interventions. They voiced understanding and agreed with the plan. The 3/19/2025 New York State Complaint (NY00375455/ iQIES 446000, not a facility reported incident) intake information documented the resident's bruising was quite extensive and involved the resident's breast and arm as well. The resident was a memory care resident and could not tell the complainant what had happened. The complainant reported the facility had given an incomplete picture of how this injury occurred. During an interview on 8/29/2025 at 9:24 AM, Licensed Practical Nurse Unit Manager #33 stated on 3/11/2025 they were notified by (former/retired) Certified Nurse Aide #34 the resident had bruises that were discovered during morning care. The bruising was quite extensive. There was no way to determine where the bruising came from. The Accident Incident Report was investigated as an injury of unknown origin. The resident wandered the unit at that time and could only answer yes and no questions. Assistant Director of Nursing #31 should have reviewed the Accident and Incident report and was responsible to determine if it needed to be reported. There were time limits to reporting but they were not certain of them. The were not sure of the conclusion of the investigation.During an interview on 8/29/2025 at 2:34 PM, the Director of Nursing stated abuse, neglect, mistreatment, and care plan violations were reported to the Department of Health. They or one of the three Assistant Directors of Nursing, or the Administrator were responsible for reporting. They referenced the New (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	York State Department of Health Nursing Home Incident Reporting Manual. The 3/11/2025 incident with Resident #50 was an injury of unknown origin because it was not witnessed. It was decided that the bruising occurred because of the resident's usual activities and did not need to be reported. Because the resident could not speak to what had happened and there were no witnesses, there was no real way of knowing what caused the bruises. The bruising was extensive, but the resident bruised easily because the resident had thrombocytopenia (a medical condition which may cause increased bruising/ bleeding). They just had to go by the whole picture and the statements that were provided. Licensed Practical Nurse #33 did the investigation and then it went to the Assistant Director of Nursing #31 for review and then they did the final sign off. The determination of whether it needed to be reported was made initially because it was time sensitive. The conclusion was the resident likely bumped into something because they did not have behaviors or exhibit aggression and therefore it did not need to be reported. The x-ray showed a partially healing clavicular fracture, so it was not acute, and that was discovered after the investigation was completed. During an interview on 8/29/2025 at 2:57 PM, Assistant Director of Nursing #31 stated injuries of unknown origin were only reported if you could not rule out abuse. Resident #50 was ambulatory and had thrombocytopenia and bruised easily. They ruled out abuse because it was determined the resident either bumped into something or leaned up against something and that would have had a significant bruising effect on them. They did not feel the incident was reportable. 10NYCRR 415.4

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observations, record review, and interview during the recertification survey conducted 8/25/2025-8/29/2025, the facility did not ensure residents were provided the appropriate treatment and services to maintain or improve their ability to carry out activities of daily living including functional communication systems for one (1) of one (1) resident (Resident #63) reviewed. Specifically, Resident #63's primary language was not English, and they were not provided with translation services. Findings include: The facility policy Resident Rights and Notice of Resident Rights and Responsibilities, dated 4/30/2024, the facility informed the resident of their rights and responsibilities in a language that was understandable to the resident. If the resident had limited English proficiency, their rights and responsibilities were presented in the resident's primary language. For foreign languages commonly encountered in the community, the facility provided the resident with written translations of their rights and responsibilities and if not common to the community, rights were communicated orally through a competent interpreter.The facility policy Translation and/or Interpretation of Facility Services, dated 4/29/2019, documented individuals with limited English proficiency had meaningful access to information and services provided by the facility. Prior to admission, the admissions representative identified a language barrier. If an interpreter was needed, the unit social worker was notified to arrange services. All persons were informed of their rights to obtain competent oral translation services free of charge. Family members and friends were not relied upon to provide interpretation services for the resident, unless explicitly requested by the resident. Resident #63 has diagnoses including diabetes, low back pain, and need for assistance with personal care. The 6/26/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, spoke a language other than English and needed or wanted an interpreter to communicate with a doctor or health care staff, and was dependent for most activities of daily living. The Comprehensive Care Plan initiated 11/5/2021 and revised 3/14/2022 documented the resident had a communication problem related to English being a second language with advancing dementia. Interventions included a translator was provided as necessary to communicate with the resident. The following observations were made of Resident #63:-On 8/25/2025 at 10:42 AM, lying in bed in a hospital gown, the call bell was on the floor under the bed. Verbal engagement was attempted, the resident just smiled and stated their name. They did not answer any questions. -On 8/26/2025 at 10:46 AM, seated in their high back wheelchair in the common area with other residents around flipping through a magazine.-On 8/27/2025 at 1:49 PM, lying in bed on their back with their eyes open. The room was silent; the television was off. Their call bell was under their pillow.-On 8/28/2025 at 9:43 AM, seated in their high back wheelchair, sleeping, in the common area with other residents around. At 1:39 PM, seated in their high back wheelchair in their room. Certified Nurse Aide #43 entered their room with a mechanical lift. There was no conversation between the resident and the certified nurse aide. At 1:42 PM, Certified Nurse Aide #43 exited the room. At 2:21 PM, Licensed Practical Nurse #42 and Assistant Director of Nursing #39 entered the room with washcloths. At 2:22 PM, Assistant Director of Nursing #39 exited the room. At 2:34 PM, Licensed Practical Nurse #42 stated Assistant Director of Nursing #39 came in to take a picture of the resident's healed thigh wound. They stated they applied nystatin (antifungal) under the resident's breasts and in their abdominal folds. During a telephone interview on 8/29/2025 at 9:51 AM, the resident's family member stated the resident did not speak any English. They visited the resident every weekend. They stated staff did not engage with the resident and there was no way for staff to communicate with them. They never saw staff use any translation services. When they came to visit, the resident was able to verbalize their needs to them in their primary language. They were able to converse with them during visits because they spoke the language. The resident was often soiled with urine and/ or feces and often stated they were hungry.During a telephone interview on 8/29/2025 at 10:03 AM, a second (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family member stated the resident did not speak any English. They visited once a week. The resident was often soiled when they came, and they told staff the resident needed their incontinence brief changed. The resident could not care for themselves. When they visited, they translated the resident's needs to the staff. They had never seen a translation service used. During an interview on 8/29/2025 at 10:43 AM, Certified Nurse Aide #43 stated Resident #63 understood English but did not speak it. They communicated with them through hand gestures. They thought the phone they used for charting had a translation application but could not recall when they used it last. The resident could point to what they wanted. During an interview on 8/29/2025 at 11:50 AM, Licensed Practical Nurse #42 the resident could say and understand some English words such as good morning and thank you but spoke a different language. They told the resident what they were doing but was not sure what they understood. Family came to visit and translated the residents needs. They were not sure if the facility had access to an interpreter. During an interview on 8/29/2025 at 12:02 PM, Licensed Practical Nurse Assistant Unit Manager #41 stated Resident #63 spoke a foreign language. The resident understood some English and would say good morning. If they asked the resident a question, they spoke in their native tongue. They did not know what the resident was saying. There was a phone number for a translation service, but they did not know what it was. They did not know why translation services were not being used but they had never utilized the service. Social work and nursing were responsible to determine an effective means of communication.During an interview on 8/29/2025 at 12:21 PM, the Director of Social Work stated determining an effective means of communication started on admission. The admissions team told social work and nursing if the resident had a primary language other than English. The facility had a contract with an interpreter service. The resident had been at the facility for years and they did not know why staff was not using the service. It was important to have effective communication to meet the resident's needs, and so they could participate in their care. 10NYCRR 415.12(a)(3)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey conducted 8/25/2025-8/29/2025, the facility did not provide ongoing programs to support each resident in their choice of activities for one (1) of one (1) resident (Resident #10) reviewed. Specifically, Resident #10 was not offered meaningful activities that included their interests and preferences. Findings include: The facility policy Recreation Goals and Objectives, updated 12/10/2019 documented the recreation department provided comprehensive recreational programming for all residents. A blend of diversional/therapeutic pursuits played a key role in providing a balance between fun/pleasure and restoration/maintenance of functional skills. It was the departments policy to provide opportunities for voluntary involvement in recreational interests/activities within both the facility and community. Resident #10 had diagnoses including autistic disorder, cardiac arrest (heart attack), and anoxic brain damage (brain is deprived of oxygen). The 8/14/2025 Minimum Data Set documented the resident had severe cognitive impairment, did not have physical or verbal behaviors, did not reject care, was dependent on staff for all activities of daily living. The 02/12/2025 Minimum Data Set documented the resident preferred reading books, newspapers, magazines; listening to music; participating in favorite activities; spending time outdoors; and participating in religious activities or practices. The Comprehensive Care Plan initiated 9/20/2021 and updated 2/26/2025 documented the resident was independent in choosing leisure activities with support from staff meeting emotional, cognitive, physical, and social needs related to an anoxic brain injury, autism, and other medical conditions not specifically noted. Interventions included ensuring activities attended were comparable with the resident's interest and age appropriate. The resident needed 1:1 in room visits and activities if not able to attend out of room events. The resident preferred Black Entertainment Television, Music Television, The Fresh Prince, music, and going outside. The 5/27/2025 quarterly Recreation Assessment documented the resident did not participate in any group activities. 1:1 activity interests included music, hearing stories, and going outside. The resident enjoyed watching television on the Black Entertainment Television channel, The Fresh Prince, and anything with actor Will [NAME]. When the resident looked away for a long period of time, that was the que they were done with the visit. The recreation activity log for June documented individual engagement with Recreational Therapist #27 was provided:-on 6/2/2025 -on 6/9/2025-on 6/23/2025 -on 6/30/2025 The recreation activity log for July documented individual engagement with Recreational Therapist #27 was provided:-on 7/4/2025 -on 7/7/2025-on 7/14/2025 -on 7/21/2025 -on 7/28/2025The recreation activity log for August documented individual engagement with Recreational Therapist #27 was provided:-on 8/25/2025 -on 8/28/2025 The following observations of the resident were made:-on 8/25/2025 at 12:31 PM sitting alone in their room in a chair in front of the television with a crime show playing. -on 8/28/2025 at 10:07 AM in bed sleeping. They smiled when asked if they liked the Actor Will [NAME] and again when asked if they liked the Fresh Prince. When asked if they could see the television from their bed they frowned. When asked if they liked what was playing on the television they frowned and closed their eyes. During an observation and interview on 8/28/2025 at 10:45 AM, Certified Nurse Aide #11 stated the resident did not communicate verbally and smiled/frowned and shook their head to communicate. They never saw activities working with the resident and the resident loved when staff came in the room and interacted with them. Resident #10 smiled. The resident was transferred from the bed to a chair that was placed parallel to the bed and staff left the room with the television out of view for the resident. During an interview on 8/28/2025 at 11:00 AM, Resident #10 was asked if they could see the television and they attempted to turn their head towards the television and frowned. They were asked if they liked music and smiled and frowned when asked if they liked the show playing on the television. During an interview on 8/29/2025 at 9:09 AM, Licensed Practical Nurse #11 stated Recreation Therapist #27 worked with (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to engage them in activities like trivia, coloring, and ice cream time. Resident #10 did not refuse care. They never saw Recreation Therapist #27 do an activity with Resident #10. They stated they cared for the resident after they were out of bed on 8/28/2025 and the positioning of the chair did not allow the resident to view the television. They liked to watch The Fresh Prince and listen to music. There used to be a video of many Fresh Prince episodes the resident watched continuously but they were not sure what happened to the video. During an interview on 8/28/2025 at 1:12 PM, Director of Recreation #63 stated they were responsible for making sure the resident floors had planned events and activities. Activities were important for the residents to have fun, and residents had the opportunity to relax and decrease their stress level. They offered a variety of activities that included exercise, dance, movies, BINGO, rosary, holy hour, mass, pizza day and taco Tuesday every month. Additionally, they did 1:1 activities with residents that were more confined to their rooms. The activities were documented in the electronic medical record by the recreation therapist. They expected each resident to be offered an activity at least once a week, but it should be three times a week. After looking at the electronic record for Resident #10 they stated they expected more 1:1 and group activities offered to the resident. During an interview on 8/29/2025 at 2:44 PM, Recreation Therapist #27 stated they were the assigned recreation therapist for the resident's floor. Recreation therapy was important to residents because it brought joy and independence to residents, gave them something to do, and worked on emotional, spiritual, and cognitive needs. They did one activity daily Monday thru Friday, and activities rotated between three floors on the weekends. They offered both group and independent activities with the residents and activities were offered at least twice a week, but they tried for three times a week. Resident #10 loved activities like watching anything with Will [NAME] and the Fresh Prince, rhythm and blues music, as well as going outside. They forgot to include or offer any activities in August prior to 8/25/2025 including 1:1 activities for Resident #10 and they had been on vacation. Activities should have been offered to the resident in their absence. 10NYCRR 415.5(f)(1)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, and interviews during the recertification survey conducted 8/25/2025-8/29/2025, the facility did not ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (1) of three (3) residents (Resident #546) reviewed. Specifically, Resident #546's bilevel positive airway pressure machine (a noninvasive ventilator that helps with breathing) was not cleaned as ordered and had brown debris in the mask. Findings Include: The facility policy Bilevel positive airway pressure, Continuous positive airway pressure Trilogy, effective 2/2020 documented non-invasive ventilator support was provided to patients with compromised airways or chronic pulmonary/cardiac diseases. Use of the machine required a physician's order, and the respiratory therapist was notified when used. The facemask was cleaned daily with sterile water and left to dry. The tubing was cleaned weekly with sterile water and left to dry. Resident #546 had diagnoses including obstructive sleep apnea (pausing of breathing during sleep, chronic respiratory failure with hypoxia (low level of oxygen in the blood), and chronic obstructive pulmonary disease (restricted airway). The 8/12/2025 Minimum Data Set assessment documented the resident had intact cognition and used bilevel positive airway pressure therapy. The Comprehensive Care Plan initiated 8/6/25 and updated 8/7/2025 documented the resident had actual/potential for altered respiratory status/difficulty breathing related to acute and chronic hypercapnic (elevated carbon dioxide levels in the blood), chronic obstructive pulmonary disease, and respiratory failure. Interventions included the use of oxygen at four liters by nasal cannula and continuous positive airway pressure/bilevel positive airway pressure therapy. The undated resident care instructions documented use of continuous positive airway pressure/bilevel positive airway pressure therapy. The 8/6/2025 Physician #10 order documented bilevel positive airway pressure therapy at bedtime. During an observation on 8/25/2025 at 11:58 a bilevel positive airway pressure machine was in Resident #546's room. The inside of the mask had brown debris in the base. During an observation on 8/27/2025 at 4:14 PM Resident #546 was in bed sleeping using their bilevel positive airway pressure therapy. The mask covered their nose and mouth, and the base of the mask contained brown debris. During an interview on 8/28/2025 at 8:45 AM, Resident #546 was in the dining room and stated at home they cared for their bilevel positive airway pressure machine, cleaned the facemask and put distilled water in the chamber daily. They did not clean the machine in the facility as staff was responsible for cleaning the machine. They used the therapy every night and when they napped during the day. The mask was dirty, and they wanted it cleaned. During an observation on 8/28/2025 at 8:48 AM the bilevel positive airway pressure mask contained brown debris throughout the mask. The Treatment Administration Record documented clean bilevel positive airway pressure equipment with sterile water and let dry every day shift clean BiPAP face/nasal mask cushion. Signed off every day in August. Licensed Practical Nurse #12 signed off as completing 8/25, 8/26, 8/27, and 8/29/2025.During an interview on 8/28/2025 at 8:50 AM, Certified Nurse Aide #11 stated they were not allowed to touch bilevel positive airway pressure machines, and the nurses were responsible for all care related to bilevel positive airway pressure therapy. During an interview on 8/29/2025 at 10:52 AM, Licensed Practical Nurse #12 stated use of bilevel positive airway pressure therapy required a physician's order. Once the order was entered, use and cleaning was documented on the treatment administration record. They were only responsible for cleaning the mask daily to limit the potential for infection and ensured distilled water was in the compartment for humidification. Respiratory Therapy was responsible for all other care regarding the therapy. They worked 8/25-8/27 and again 8/29 and did not clean the mask. On 8/25/2025 the resident was wearing the mask all day, and they forgot to clean it every other day they worked. They signed off they cleaned the mask and should not have and stated they were going to clean it because it had a lot of brown debris in the mask. During an interview on 8/29/2025 at 8:57 AM, Respiratory Therapist #6 stated they were notified when (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents were admitted to the facility using bilevel positive airway pressure/continuous positive airway pressure therapy. They were responsible for putting in the order and the initial assessment of the machine. Nursing was responsible for cleaning the mask daily because nasal and saliva drainage collected in the mask and facial oils could breakdown the mask. It was an infection control issue, and the mask could lose durability. They gave the resident a new machine when they were admitted because the machine they came with was too dirty to use. After looking at the mask they stated it was filthy and needed cleaning. During an interview on 8/29/2025 at 11:37 AM, Registered Nurse Unit Manager #9 stated a physician's order was required for bilevel positive airway pressure/continuous positive airway pressure. The order created a template that automatically populated on the treatment administration record so the nurse would know when to clean the facemask, when to change the tubing, and when to clean the continuous positive airway pressure. Resident #546 was admitted to the facility and utilized bilevel positive airway pressure therapy. They expected masks to be cleaned as ordered for infection control reasons. 10 NYCRR 415.12(k)(6)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observations, record review, and interviews during the recertification survey conducted 8/25/2025-8/29/2025, the facility did not ensure pain management was provided to residents who required such services consistent with professional standards of practice for one (1) of one (1) resident (Residents #21) reviewed. Specifically, Resident #21 did not have their prescribed pain patch placed as ordered and they did not have the effectiveness of their pain treatment documented.Findings include:The facility policy Pain Assessment, Management, and Evaluation, dated 12/16/2024, documented the resident would receive appropriate and timely assessment, evaluation, and treatment with pain-relieving drugs, adjunctive drugs, and non-drug therapies as needed and in accordance with best practice standards. Pre-pain assessment and post administration pain assessment must be completed on all pain medications in the indicated areas. In the Electronic Medical Record when an order was written for a routine pain medication, the order automatically triggered a pre pain level to be documented. An additional order must be written labeled routine post that would trigger a post pain level to be documented. The facility policy Medications: Ordering Process, dated 4/29/2025, documented the residents' need to receive medications in a timely basis was the facility's priority. Medications were to be ordered to maintain an adequate supply for a 48-72-hour supply available. Medications were not to be circled as unavailable. Medication was to be obtained via the electronic via the electronic interim box or call the pharmacy to have the medication sent from the backup pharmacy. The floor nurse was responsible to order floor stock medications from the ordering company.Resident #21 has diagnoses including spondylopathy (degeneration of the lower spine), postherpetic neuralgia (damage to the nerves from shingles), and osteoarthritis (joint disease). The 8/7/2025 Minimum Data Set documented the resident was cognitively intact, was on scheduled pain medication, received non-medical interventions for pain, and had moderate pain. The 8/16/2025 Comprehensive Care Plan documented the resident had acute/subacute/chronic pain related to history of herpes zoster and postherpetic neuralgia, osteoarthritis, and bilateral lower edema. Interventions included to monitor, document, and report to the nurses any complaints of pain or requests of pain treatment from the resident, notify the physician if interventions were unsuccessful or if the complaint was a significant change from the resident's past experiences of pain, observe and report changes in the resident's routine, and provide the resident and their family with information about pain and options available for pain management, and document the discussed preferences.The 6/9/2025 physician order documented apply a lidocaine pain relief external patch 4% (topical pain patch) to the right lower extremity and back topically one time a day for pain; please put on in the morning and remove 12 hours later at 8:00 PM. There was no documented pre- and post-administration pain scale related to the lidocaine pain relief patch. The August 2025 Medication Administration Record documented on 7/22/2025, 7/23/2025, and 7/24/2025 the lidocaine patch was not administered and to see the nurses' notes. The 7/22/2025, 7/23/2025, and 7/24/2025 Order Administration Notes (nursing notes) documented the resident's lidocaine pain patch was out of stock. During an interview on 8/26/2025 at 9:28 AM, Resident #21 stated quite often the facility was out of the pain patches for their back and they recently went four days without it. The nurse from the day before had to get them from another floor. During a follow up interview on 8/27/2025 at 2:01 PM, Resident #21 stated they had osteoarthritis in their hands, knees, and back and they were in pain all the time. Their lidocaine patch was not applied in a few days as the supply was not ordered in time. They stated they went without the patch, and they had a lot of back pain. During an interview on 8/28/2025 at 11:03 AM, Central Supply Staff #45 stated it was their responsibility to deliver all supplies to the units. The units would call down and leave messages for what they needed, and they delivered it. They stated lidocaine patches at 4% were kept as a regular stock item. The unit secretaries called them with the quantity of patches they needed. If it was a weekend and something was needed, the supervisor and security had a key to Central Supply. During an interview on (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/28/2025 at 11:20 AM, Licensed Practical Nurse #46 stated Resident #21 was evaluated for pain by interview. It was documented under vitals but Resident #21's pain levels had not been documented since June. The resident should have been evaluated for their pain. They were supposed to reapproach the resident after pain intervention administration to see if it was effective. Usually, a resident had a pop up on their Medication Administration Record to record the effectiveness of the intervention, but Resident #21 did not. During an interview on 8/28/2025 at 11:31 AM, Licensed Practical Nurse Unit Manager #47 stated if a medication was an over-the-counter stock medication it came from Central Supply. The unit secretary normally called Central Supply to obtain a needed stock medication. Lidocaine patches were stock medication. If a resident ran out of lidocaine patches, they would be obtained from central supply. If it was a weekend, the nurse should call the supervisor. If the facility was out of lidocaine patches, the provider should be notified. Resident #21 went three days without a lidocaine patch. They did not know why Resident #21 had missed three days of patches. Typically, a resident had a supplementary pain scale entered when they had a pain intervention order. The nurses documented pain evaluations under vital signs, and the resident did not have any documented that month. 10NYCRR 415.12

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews during the recertification survey conducted 8/25/2025-8/29/2025, the facility did not ensure that residents who required dialysis (treatment to filter waste products from the blood when the kidneys do not work) received such services consistent with professional standards of practice for two (2) of two (2) residents (Residents #7 and #336) reviewed. Specifically, Residents #7 and #336 did not have pre-and post-dialysis assessments as ordered. Findings include:The facility policy Dialysis Care, dated 4/2025, documented residents receiving dialysis were to have a care plan and all dialysis observations, assessments, and care must be documented in the medical record on each dialysis day prior to dialysis and upon return. The order set and template were to be added to the resident's orders which included the Dialysis: Daily Observation/Assessment and interfacility transfer report order. The Dialysis Observation/Assessment was completed on each dialysis day, prior to dialysis and upon return. 1) Resident #7 had diagnoses including end stage kidney disease, dependence on renal dialysis, and dementia with behavioral disturbance. The 7/9/2025 Minimum Data Set assessment documented the resident was cognitively intact, had no behaviors, and was on dialysis. The 4/5/2023 Comprehensive Care Plan documented the resident received hemodialysis related to renal failure with an arteriovenous fistula (connection between an artery and a vein used for dialysis access) in the right upper arm and attended dialysis on Tuesday, Thursday, and Saturday at 11:15 AM. Interventions included to monitor the resident's vital signs and monitor, document and report any signs of infection to the access site, renal insufficiency, peripheral edema, and bleeding. The 5/2/2025 physician order documented to complete the dialysis assessment before and after dialysis two times a day every Tuesday, Thursday, and Saturday. Go into the resident's clinical chart, under assessments tab, select new, select Dialysis Observation/Assessment and complete. The resident's July 2025 and August 2025 Medication Administration Record documented the pre-and post-dialysis assessments were completed every Tuesday, Thursday, and Saturday except for post-dialysis on 8/26/2025 when the resident was not available. The resident's electronic medical record documented: -July 2025: one pre-dialysis assessment on 7/17/2025 and two post-dialysis assessments on 7/8/2025 and 7/10/202025. -August 2025: one pre-dialysis assessment on 8/23/2025 and two post-dialysis assessments on 8/7/2025 and 8/28/202025. There was no documented evidence the resident had consistent pre and post dialysis assessments three times a week on dialysis days as ordered. During an interview on 8/29/2025 at 12:39 PM, Licensed Practical Nurse #22 stated if a resident went to dialysis on their shift, they should obtain vital signs before and after dialysis, fill out the dialysis communication form in the resident's dialysis book to send with them, check the dialysis site, and check the communication book form when the resident returned. The dialysis communication form should be filled out prior to dialysis and then reviewed upon return from dialysis. The pre- and post-dialysis assessments were recorded on the communication form for pre-dialysis and on the (continued on next page)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment administration record or a progress assessment when the resident returned from dialysis. If the pre- and post-dialysis assessments were marked as completed in the medication administration record it meant the nurse got the vital signs, filled out the communication form, and the dialysis site was fine. The pre-assessments they completed for dialysis were marked on the communication form. During an interview on 8/29/2025 at 1:39 PM, Registered Nurse Unit Manager #54 stated when a resident went to dialysis, the licensed practical nurse should obtain their vital signs, record them on the dialysis communication form, check the dialysis site, and send the communication book with the resident to dialysis. Upon return from dialysis, the licensed practical nurse should assess the resident's dialysis site and dressing, obtain vital signs, document the vital signs in the treatment administration record and the dialysis assessment, and check the dialysis communication book to ensure there were no issues. The licensed practical nurses were supposed to complete pre- and post-dialysis assessments. If pre- and post- dialysis assessments were signed off as completed in the medication administration record, they should have been completed. They did not review if assessments and the communication book sheets were completed. They did a medication administration record and treatment administration record audit looking for blank boxes to indicate the assessments were not completed. They were unaware most of Resident #7's pre- and post-dialysis were not completed for July and August 2025. The assessments should be completed as it was an order. 2) Resident #336 had diagnoses including end stage kidney disease and dependance on renal dialysis. The 8/17/2025 Minimum Data Set assessment documented the resident had intact cognition, had end stage renal disease, and received dialysis. The Comprehensive Care Plan initiated 7/8/2025, documented the resident had renal insufficiency related to end stage renal disease. Interventions included dialysis, dietary consultation, and lab work. The 6/28/2025 Medical Director #10 order documented hemodialysis Tuesday, Thursday, and Saturday at 7:05 AM with 6:00 AM pick up. The 8/18/2025 Nurse Practitioner #65 progress note documented Resident #10 was examined with diagnosis including chronic kidney disease and end stage renal disease. The resident was sent to the hospital on 6/23/2025 because their fistula (connection between an artery and vein used for dialysis) malfunctioned. They previously had a fistula revision on 5/12/2025. There was no documented vital signs or assessment documented on the dialysis interfacility transfer patient report for June, July, or August 2025. During an observation and interview on 8/25/2025 at 11:15 AM, Resident #336 stated they went to dialysis Tuesday, Thursday, and Friday and went with a communication book. The nurse took their vital signs and documented them on a paper that was put in their book for the dialysis center. The book contained the 8/21/2025 sheet and they were not sure where the August sheets were if they were not in the book. During an observation on 8/29/2025 at 9:41 AM Resident #336's dialysis communication book included only documentation for pre dialysis on 8/21/2025 and 8/26/2025. During an interview on 8/29/2025 at 9:41 AM, Registered Nurse Unit Manager #9 stated residents that received dialysis had vital signs completed and documented in a communication book before leaving (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	08/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for dialysis and when they returned. The nurse documented any new issues with the resident, any medications the resident received prior to dialysis, any issues with the fistula, and if applicable the status of the portacath (implanted device for long term access to the vein) dressing. When the resident returned vital signs were taken and the fistula and/or partacath site were assessed and documented on the sheet in the communication book. They expected this to be completed on all dialysis residents. Resident #336 received dialysis and should have all the documentation in the dialysis book. They stated only the 8/21/2025 and 8/26/2025 sheets were in the book and lacked documented post dialysis information. They were not sure where the remainder of the sheets were or why the post dialysis assessments were not documented. During an interview on 8/29/2025 at 12:12 PM, Licensed Practical Nurse #12 stated when a resident received dialysis vital signs were taken before and after dialysis. The purpose of the communication book was for dialysis to know what medications the resident had taken and if they were stable to receive dialysis. They had one resident that received dialysis, Resident #336. They only thing they did when the resident returned from dialysis was take vital signs. They did not look at the fistula or the portacath or document anything in the communication book because it was only used by the shift that sent the resident to dialysis. 10 NYCRR 415.12(K)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review during the recertification survey conducted 8/25/2025-8/29/2025, the facility did establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of five (5) residents (Resident #282) reviewed. Specifically, Resident #282 was on enhanced barrier precautions and Certified Nurse Aides #56 and #57 did not wear proper personal protective equipment while performing care. Findings included:The facility policy Infection Prevention and Control Program for Long Term Care Facilities, dated 10/30/2024, documented the program was to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors, and healthcare workers. Employees were to adhere to all policies and procedures related to infection control.The facility policy Enhanced Barrier Precautions, dated 1/28/2025, documented Enhanced Barrier Precautions were an infection control intervention to reduce transmission of resistant organisms by employing gown and glove use during high contact resident care activities. Staff were required to use gown and gloves during high-contact resident care to prevent the transmission of organisms. Those activities included dressing, bathing, toileting, and providing hygiene. This type of precautions would be used for any resident with an indwelling medical device or wound.Resident #282 had diagnoses including right below knee amputation. The 8/21/2025 Minimum Data Set assessment documented the resident had intact cognition; was dependent for mobility, toileting hygiene, bathing, and dressing; required moderate assistance for personal hygiene; was occasionally incontinent of bladder; frequently incontinent of bowels; had an unstageable pressure ulcer; and had surgical wounds. The 6/25/25 revised Comprehensive Care Plan documented the resident required enhanced barrier precautions related to below knee amputation. Interventions included ensure personal protective equipment, gowns, gloves, and alcohol-based hand rub were readily accessible to staff near or outside the resident's room; trash can was placed inside the room near the exit for discarded personal protective equipment; physician order in place for enhanced barrier precautions; special instructions updated to reflect need for enhanced barrier precautions; enhanced barrier precautions signage outside of the resident's room; and personal protective equipment required when performing high contact resident care activities. The 8/26/2025 Kardex (care instructions) documented special instructions of enhanced barrier precautions related to a wound. During an observation on 8/27/2025 at 1:37 PM, Resident #282's room had two Enhanced Barrier Precautions signs on the wall next to the doorway. Certified Nurse Aides #56 and #57 were performing personal hygiene and positioning the resident. The aides wore gloves and did not wear surgical gowns while performing care The aides left the room at 1:40 PM. During an interview on 8/28/2025 at 10:27 AM, Licensed Practical Nurse #20 stated the resident was on enhanced barrier precautions due to an open area. Facility staff were educated on precautions and personal protective equipment yearly and as needed. The purpose of precautions was to prevent the transmission of germs from a resident to staff or another resident. Staff should wear a gown and gloves while performing resident care. The nurse stated they looked into the room when the aides were performing care and neither aide was wearing a gown. During an interview on 8/28/2025 at 10:46 AM, Certified Nurse Aide #56 stated they received infection control education including personal protective equipment education in the past. Personal protective equipment should be worn to prevent the transmission of diseases. Any room where that equipment was required had a sign on the doorway. The required personal protective equipment was stationed near that room. They stated Resident #282 was on precautions and staff should wear a gown and gloves while performing care. They stated they forgot to put it on prior to caring for the resident. During an interview on 8/28/2025 at 11:05 AM, Registered Nurse Manager #21 stated Resident #282 had an open wound and was on enhanced barrier precautions. Staff should wear a gown and gloves while performing direct resident care to prevent cross-contamination of germs. During an interview on 8/28/2025 at 4:06 PM, the (continued on next page)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Infection Preventionist stated the expectation of enhanced barrier precautions was when staff performed direct resident care, they wore gowns and gloves. Staff knew what type of precautions a resident was on as it was documented in the resident record, a sign was on the doorway, and the appropriate personal precaution equipment was stored outside the resident's door. The resident should have a physician order for the type of isolation precautions needed. Personal protective equipment for enhanced barrier precautions included a gown and gloves while performing direct resident care. 10NYCRR 415.9(a)(b)