| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335190 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Jewish Home of Central New York | 4101 E Genesee St<br>Syracuse, NY 13214 |

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 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>(continued on next page) |

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

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

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on record review and interview during the abbreviated survey (iQIES #734057), the facility did not ensure residents received proper foot care and treatment in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for one (1) of three (3) residents (Resident #3). Specifically, Resident #3 was recommended for routine podiatry care by a wound care provider and there was no documented evidence of podiatry care in the resident's record for eight (8) months. Findings include: The facility did not have a documented policy/procedure that addressed how podiatry consults were obtained or who was responsible to schedule them. Resident #3 had diagnoses including Alzheimer's Disease, diabetes and peripheral vascular disease (reduced blood flow to the limbs). The 02/04/2024 Minimum Data Set assessment documented the resident's cognition was moderately impaired; they were at risk of pressure ulcers, and they had no unhealed pressure ulcers or venous or arterial ulcers. The 08/06/2024 renewal physician order, (first became a standing order on 07/28/2023), documented podiatry consultation. The 08/12/2024 podiatry note documented the resident's toenails were debrided (removal of significantly thickened, diseased or damaged nails using specialized tools). They recommended continued wound care for superficial ulceration to tip of right toe until resolved. The 09/05/2024 Wound Nurse Practitioner #9 note documented the resident had an ulcer in the presence of diabetes. The ulcer on their right great toe was 0.5 centimeters wide x 0.5 centimeters long with 100% eschar (non-viable tissue). The plan was to continue Betadine (wound treatment) to the toe twice daily and continue routine podiatry visits. From 09/2024 through 04/2025, Wound Nurse Practitioner #9 continued to assess the resident's right foot weekly and recommended routine podiatry visits. There was no documented evidence the resident was seen by podiatry from 08/12/2024 through 04/29/2025. The 03/25/2025 Comprehensive Care Plan documented the resident had impaired skin integrity, diabetes and needed assistance with activities of daily living. Interventions included wound care and assistance with grooming and hygiene needs. The plan did not address nailcare or need for podiatry. The 04/14/2025 Physician #10's vascular consult documented the resident developed a wound on the top of the right second toe and the tip of the fourth toe of the left foot. A follow up with the podiatrist was necessary for nail care. The 04/30/2025 podiatry note documented the resident had a diabetic ulcer on the right second toe, they had dry skin and no signs of infection. Plan: lotion to both feet every other day and Iodine dressing to right foot second toe every other day. During an interview on 11/13/2025, Registered Nurse Manager #7 stated the facility had a podiatrist who came to the facility every three (3) months. If a resident needed to be seen sooner, they could be sent to an outside podiatrist. When a recommendation was made to see podiatry, the nurse was responsible to let the medical receptionist know to schedule the appointment. They stated they started working for the facility in April of 2025 and they had no knowledge of concerns with obtaining podiatry appointments prior to their start date. However, because the resident had diabetes, only a podiatrist was allowed to cut the resident's nails. They expected the resident's nails to be trimmed by podiatry every three (3) months and were not sure why they went eight (8) months with no documented nail care. During an interview on 11/14/2025 at 10:30 AM, Wound Nurse Practitioner #9 stated they saw the resident weekly since 2024 for wounds on their feet. They recommended podiatry in their consults because podiatry helped with nail care. They stated from what they recalled, it was difficult to tell where the resident's toenails were due to eschar that was present. They believed residents should be seen by podiatry every three (3) months and although Nurse Practitioner #9 and a vascular physician cared for the resident's feet, neither of them provided routine nail care. During an interview on 11/18/2025 at 10:16 AM, Chief Nursing Officer #3 stated there was no documented process for how podiatry consults got scheduled or who was responsible to ensure scheduling. They had spoken with their Director of Nursing and the unit secretary who verbally told them the process and they would be updating their policy to include this information. Staff were aware of the process even though it was not documented. Diabetic residents had toenail care provided by a podiatrist only. If a provider recommended routine podiatry, it was the responsibility of the unit manager to arrange the consult. The resident should have been seen for toenail care between 08/2025 and 04/2025. 10 NYCRR 415. 12(k)(7) |