STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335190	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Home of Central New York	4101 E Genesee St 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for three (3) of eight (8) residents (Residents #79, #68, and #32) reviewed. Specifically, Resident #79 had unclean and untrimmed fingernails and was not assisted with removing unwanted facial hair; Resident #68 was not provided with assistance during meals as planned; and Resident #32 had soiled clothing with food debris. Findings include:The facility policy ADL Care, revised 06/2025, documented each morning and evening, care would be provided according to the resident's level of assistance to include elimination and peri care, partial bathing, mouth care, hair combing, and dressing. Fingernails and toenails were kept clean and at the appropriate length, females would be free from facial hair unless they choose not to have the hair removed, meal set up would be provided by staff and residents would receive assistance with meals as needed, and residents would be provided the opportunity to choose their clothing and if unable, staff would provide choices. 1) Resident #79 had diagnoses including kidney failure and atrial fibrillation (irregular heartbeat). The 02/13/2026 Minimum Data Set (assessment tool) documented the resident was cognitively intact, required partial/moderate assistance with personal hygiene, was dependent for showers and bathing, and did not reject care. The Comprehensive Care Plan initiated 01/29/2026 documented the resident had a focus area in all activities of daily living. Interventions included providing morning and nighttime care and providing grooming and hygiene needs. The undated care instructions documented the resident required partial/moderate assistance with personal hygiene. Resident #79 was observed at the following times: -on 03/04/2026 at 11:48 AM, with multiple patches of white and gray hair on their upper lip, chin, and the top of their neck. Their fingernails were long and had dark brown debris under all five nails on their right hand. The resident stated they did not want hair on their face. -on 03/05/2026 at 3:28 PM, with multiple patches of white and gray hair on their upper lip, chin, and the top of their neck. -on 03/06/2026 at 9:46 AM, with multiple patches of white and gray hair on their upper lip, chin, and the top of their neck. Their fingernails were long and had dark brown debris under all five nails on their right hand. At 10:00 AM, the resident stated they were already cleaned up that morning and staff did not offer to shave them so the hair would just stay on their face. (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: 335190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
NAME OF PROVIDER OR SUPPLIER Jewish Home of Central New York		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 E Genesee St Syracuse, NY 13214	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-on 03/09/2026 at 1:49 PM, with multiple patches of white and gray hair on their upper lip, chin, and top of their neck. During an interview on 03/10/2026 at 9:53 AM, Certified Nurse Aide #32 stated they were familiar with Resident #79, and cared for them on 03/04/2026, 03/05/2026, 03/06/2026, 03/09/2026 and 03/10/2026. Resident #32 required total care assistance and never refused care. They noticed the resident's facial hair, but they were very busy during their shifts, so they did not have time to shave the resident. They planned to do it before the end of their shift because it was very noticeable. They were unsure if they were allowed to trim fingernails, but they could clean them. They stated they were not aware the residents had long nails with dark debris underneath. During an interview on 03/10/2026 at 10:54 AM, Licensed Practical Nurse #33 stated personal hygiene consisted of shaving and nail care and was completed daily during every shift by the certified nurse aides. They did not notice Resident #79's facial hair. They thought the resident was diabetic so they were responsible to trim their nails, but the certified nurse aides should keep them clean. During an interview on 03/10/2026 at 11:06 AM, the Assistant Director of Nursing stated personal hygiene consisted of shaving and nail care and was completed daily for every resident by the certified nurse aides. The nurses were responsible for trimming the nails of residents who were diabetic, but nails should always be clean. They were familiar with Resident #79, and they noticed their facial hair a week ago. They spoke with staff at that time and thought they had removed the facial hair. They were not aware the resident had long and dirty fingernails. 2) Resident #68 had diagnoses including dementia and depression. The 01/14/2026 Minimum Data Set (assessment tool) documented the resident had severe cognitive impairment, did not exhibit behavioral symptoms, did not reject care, and required substantial to maximum assistance with eating. The Comprehensive Care Plan updated on 02/18/2026 documented the resident had a focus area in all activities of daily living. Interventions included maximum assistance with eating a mechanically soft diet. The undated care instructions documented the resident required substantial/maximal assistance with eating and was upgraded to a mechanical soft consistency diet on 02/11/2026. During observations on 03/04/2026 Resident #68 was observed sitting at the end of a large oval table, asleep in their chair waiting for lunch on 03/04/2026 at 12:08 PM. At 12:18 PM, they were provided with their meal. No one assisted the resident with their meal, and they remained asleep. At 12:30 PM, Certified Nurse Aide #11 sat down to assist the resident, and at 12:31 PM, they stood up and left the resident. At 12:33 PM, Licensed Practical Nurse #16 sat down to assist the resident. At 12:36 PM, Licensed Practical Nurse #16 stopped assisting Resident #68 and began assisting another resident at the table. At 12:51 PM, Licensed Practical Nurse #16 assisted the resident with their meal again and at 12:58 PM, the resident finished their meal and was removed from the table. During an observation on 03/06/2026 at 12:44 PM, Certified Nurse Aide #31 assisted Resident #68 with their meal and stopped to assist Resident #108. At 12:57 PM, Certified Nurse Aide #31, was not assisting Resident #68 with their meal while sitting next to the resident discussing with other nursing staff who would need to be toileted after lunch. At 1:06 PM, Resident #68 fell asleep and Certified Nurse Aide #31 did not attempt to wake the resident or encourage them to eat and removed the (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident from the table. The resident had 50% of their food remaining on their plate, their juice was not opened, and the pureed cherry pie was not touched. During an interview on 03/09/2026 at 8:30 AM, Licensed Practical Nurse #16 stated Resident #68 needed to be assisted with their meal. The resident would say no sometimes, but staff should keep trying. During an interview on 03/10/2026 at 10:08 AM, Certified Nurse Aide #11 stated the resident needed assistance with their meals. There were no assignments for feeding assistance. Staff should sit down and assist a resident. They were not sure if the resident had finger foods and that was why they did not assist them on 03/04/2026 and 03/06/2026 during the noon meal. They stated it was not uncommon to start assisting other residents if the resident said they did not want to eat, but they should continue to encourage them to eat. During an interview on 03/10/2026 at 10:43 AM, Registered Nurse Unit Manager #14 stated if a resident needed assistance any staff in the dining room should assist. Some residents required encouragement and others needed physical assistance. Resident #68 required substantial assistance and needed to be fed. 3) Resident #32 had diagnoses including dementia, depression, and anxiety. The 12/19/2025 Minimum Data Set (assessment tool) documented the resident had severe cognitive impairment, increased in verbal behavioral symptoms directed toward others, did not reject care, and was dependent on staff for most activities of daily living. The Comprehensive Care Plan initiated 11/24/2025, documented the resident had a focus area on activities of daily living and required assistance by staff. Interventions included anticipating the residents' needs for morning and night care. The undated care instructions documented the resident was dependent on staff for dressing the upper and lower body. Resident #32 was observed with soiled clothing, and white and brown substances on the front of their pants and shirt on 03/04/2026 at 10:15 AM and 10:40 AM; and 03/09/2026 at 10:35 AM, and 12:45 PM. During an interview on 03/09/2026 at 1:30 PM, Certified Nurse Aide #11 stated Resident #32 was dependent on staff for care and that included changing their clothing if they were soiled. They were responsible for Resident #32's care and included ensuring the resident's clothing was clean. During an interview on 03/10/2026 at 11:15 AM, Registered Nurse Unit Manager #14 stated Resident #32 was dependent on staff for all personal care. They expected staff assigned to the resident to change their clothing if they were visibly soiled. During an interview on 03/10/2026 at 12:20 PM, the Director of Nursing stated residents should not wear soiled clothing. They expected staff to change the resident's clothing if soiled. 10 New York Codes, Rules and Regulations 415.12(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during the recertification survey, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one (1) of one (1) resident (Resident #120) reviewed. Specifically, Resident #120 was admitted with wounds and did not have admission orders for wound care, a timely assessment by a wound care provider, and their outside wound care clinic appointment was canceled by the facility. Findings included: The facility policy admission Process, last reviewed 09/2025, documented the facility ensured all residents were admitted in a manner that promoted safety, continuity of care, and respect for resident rights. On admission, a licensed nurse completed an initial nursing assessment, assessed skin condition, and reviewed medications and treatment. Required orders on admission included treatments for wound care, rehabilitation services if indicated, and infection control precautions.The facility policy Wound Care and Wound Rounds Protocol, created 03/2024, documented all new admissions had a complete skin assessment to identify any open areas. New admissions with open areas of skin required a registered nurse to document the admission skin assessment, with size, appearance, and stage if appropriate. The physician was notified, and treatment orders were obtained. A wound consultant was notified, and the resident was added to the wound roster. Residents were seen weekly for wound rounds.Resident #120 had diagnoses including gangrene in their right leg (dead tissue) and peripheral vascular disease (poor circulation). The 01/28/2026 Minimum Data Set assessment documented the resident had intact cognition, was dependent for most activities of daily living, frequently incontinent, and at risk of pressure ulcers. The 01/16/2026 Hospital Discharge Summary documented the resident had an admission diagnosis of right foot pain and gangrenous changes to the right foot. The magnetic resonance imaging (a test that produces 3D images) noted possible osteomyelitis (bone infection). The resident was to follow-up with the wound clinic for hyperbaric oxygen therapy (medical treatment where patients breathe 100% oxygen in a pressurized chamber to enhance tissue oxygenation and promote healing). Treatment included an iodine skin-prep and dry dressing to the gangrenous wound, change daily, keep the area dry and prevent secondary soft tissue infection, and offloading as tolerated in a [NAME] shoe (a specialized orthopedic device designed to shift weight off the wound).The 01/16/2026 admission Assessment completed by Registered Nurse #18 documented the resident had a warm and swollen right fourth and fifth toe with a betadine dressing that was clean, dry, and intact. There was no documented evidence of the type and characteristics of wound the dressing was used for.There was no documented evidence of wound care orders for the right foot upon admission to the facility.The Comprehensive Care Plan initiated 01/16/2026 documented the resident was at risk for skin breakdown. Interventions included encouraging adequate dietary intake, occupational/physical therapy as necessary, and weekly comprehensive skin assessments. On 01/20/2026 the care plan documented the resident had a wound infection and interventions were to monitor discomfort related to wound and medicate as necessary, monitor vital signs, and perform treatment and change dressings as ordered. The resident was at risk for skin breakdown with interventions including certified nurse aide report of skin condition daily, complete pressure ulcer risk assessment, encourage adequate nutrition, maintain turning and positioning schedule every two to four hours with staff assist, and skin check/care every shift and with showers. The 02/09/2026 Registered Nurse Unit Manager #19 progress note documented the resident's family made an appointment with a specialized wound clinic that was recommended by the hospital and would pick up the resident and bring them to the appointment. The facility was to gather required paperwork for the appointment.The 02/10/2026 Registered Nurse Unit Manager #19 progress note documented they were made aware by the Chief Nursing Officer the resident needed to be evaluated by the in-house wound care team and could not make the outside appointment for a specialist. Staff were told not to let the resident leave for the appointment.The 02/10/2026 revised (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Care Plan for skin breakdown documented the resident had actual skin breakdown with interventions including assessing pain and medicating before wound treatment, protecting and off-loading heels, weekly comprehensive skin assessment and documentation, weekly wound measurement and documentation, and perform wound treatment as ordered.The 02/12/2026 Nurse Practitioner #20 wound care note documented it was their first evaluation of Resident #120 who presented to the facility for management of worsening arterial ulceration to their right toes. They had pre-existing ulcers of the right toes and right heel. The resident would have benefited from hyperbaric oxygen therapy. The 02/12/2026 provider orders documented the following wound care for the toes on the right foot. Wash area with normal saline; pat dry; soak the gauze in betadine; cover the toes with the betadine-soaked gauze; cover the area with an abdominal pad; and secure the dressing with woven gauze roll bandage.The 02/13/2026 provider orders documented the following wound care for the right heel arterial ulcer. Clean the area with wound cleanser; apply betadine to the base of the wound; leave open to air twice a day. The resident did not have wound care orders for 27 days.During an interview on 03/06/2026 at 1:39 PM, Assistant Director of Nursing #21 stated wound care orders were placed on admission when residents had wounds on admission, and the wound care provider saw residents within a week from admission. Residents were not required to be seen by the facility wound provider prior to going to specialized appointments recommended by the hospital.During an interview on 03/06/2026 at 3:20 PM, the Director of Nursing stated when a resident was admitted from the hospital with wounds, wound orders were placed within 48 hours from admission and were received from the hospital discharge summary or the after-visit summary. If there were no wound orders in the hospital paperwork a phone call was made to the provider for wound care orders. The wound care team saw the residents the next Thursday after admission. Resident #120 was admitted to the facility on [DATE] with wounds on their toes and heel of the right foot. There were no wound care orders placed on that day or within 48 hours of admission. There were orders for wound care in the hospital discharge summary, the registered nurse who oversaw placing orders must not have seen the orders and stated they were missed as they were on the bottom of the page and betadine was not on the after-visit summary. The admission assessment by Registered Nurse #18 documented the resident had wounds on their right foot. They expected the admission nurse or the unit manager to note the betadine dressing on their foot and ensure orders were in place on admission. The wound care provider did not assess the resident in a timely manner; since there were no wound care orders placed on admission it did not trigger the wound care team to see the resident. Wound care orders should be placed on admission, and the wound care team should have assessed the resident prior to 02/12/2026. Residents were not required to see the facility wound care team prior to going to an out of facility wound center. They were not sure why the appointment was canceled as it came from the Chief Nursing Officer.During an interview on 03/09/2026 at 10:30 AM, Licensed Practical Nurse #22 stated wound care for residents was found under treatment orders. If orders were not there, they called the supervisor to obtain orders. Supervisors or the unit manager was responsible for placing orders. Resident #120 was admitted with wounds on their right foot. They were unable to remember if there were wound treatments on admission.During an interview on 03/09/2026 at 10:46 AM, Registered Nurse #18 stated they were not responsible for placing orders on admission as they were not taught how to do so. They did the admission assessment for Resident #120 but did not remember if there were wounds. The unit manager, Registered Nurse Unit Manager #19, was responsible for placing orders.During an interview on 03/09/2026 at 3:45 PM Registered Nurse Unit Manager #19 stated on admission, wound care orders were found in the hospital discharge summary or the after-visit summary. If there were no orders, they called a provider to obtain them. The admission assessment for Resident #120 was conducted by Registered Nurse #18. Since they did the admission and was a registered nurse, they were responsible for placing the wound care orders. They were unsure why the orders were missed. They were not responsible for checking orders during the resident's stay at the facility. The resident should have had wound care orders. They were told to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cancel the resident's specialized wound care appointment by the Chief Nursing Officer because the facility was not going to incur the costs unless the facility wound care team said they needed it. The Chief Nursing Officer then had the wound care provider assess the resident. 10 New York Codes, Rules and Regulations 415.1

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for three (3) of three (3) test trays (one lunch tray on 03/06/2026 and two breakfast trays on 03/10/2026). Specifically, the lunch tray and breakfast trays included hot foods served below 110 degrees Fahrenheit and cold foods served above 60 degrees Fahrenheit and were not palatable. Findings include:The facility policy Food Palatability, revised 05/2024, documented hot food would be served at no less than 135 degrees Fahrenheit and cold food would be served no higher than 40 degrees Fahrenheit. Meals would be delivered to the units in heated/cooled food transport carts and plugged in on the floors to maintain a meal temperature palatable to most residents. During an observation on 03/06/2026 at 1:15 PM, Resident #9's lunch meal was tested, and a replacement meal was ordered. Food temperatures were measured and verified by Licensed Practical Nurse #7 and were as follows: fried chicken was 107 degrees Fahrenheit, matzo ball soup was 131 degrees Fahrenheit, diet cola was 63 degrees Fahrenheit, ginger ale was 63 degrees Fahrenheit, and water was 63 degrees Fahrenheit. The fried chicken tasted bland, and the beverages all tasted lukewarm. During an interview on 03/06/2026 at 1:15 PM, Licensed Practical Nurse Manger #7 stated the carts were meant to keep the cold items cold and warm items hot. The unit staff should serve the trays table by table and that was not how the carts were set up. Staff had to go from cart to cart looking for the correct resident and then a nurse had to verify the tray accuracy before it could go to the resident. During an observation on 03/10/2026 at 8:50 AM, a blue meal transport cart was delivered to the unit and plugged in. There was a sign posted on the side of the cart that read, Please do not plug in or turn on, repair company has been notified. A second delivery cart was delivered and plugged in. During an observation on 03/10/2026 at 9:02 AM, a hospitalized resident's breakfast tray was tested from the broken food cart. Food temperatures were measured and verified by Licensed Practical Nurse #44 and were as follows: egg and cheese croissant was 95 degrees Fahrenheit, cottage cheese was 68.2 degrees Fahrenheit, and whole milk was 55.4 degrees Fahrenheit. The egg and cheese croissant tasted cold, and the cottage cheese and milk tasted warm. During an observation on 03/10/2026 at 9:08 AM, a second hospitalized resident's breakfast tray was tested from the functioning meal cart. The food temperatures were measured and verified by Licensed Practical Nurse #44 as follows: egg and cheese croissant was 101.8 degrees Fahrenheit, skim milk was 58.1 degrees Fahrenheit, cottage cheese was 68.7 degrees Fahrenheit, and oatmeal was 128 degrees Fahrenheit. Two pancakes were provided, although the tray ticket documented waffles. The egg and cheese croissant tasted cold, the pancakes were cold (butter would not melt on them), and the milk and cottage cheese tasted warm. During an interview on 03/10/2026 at 9:13 AM, Certified Nurse Aide #45 stated they got complaints about the food sometimes and usually had to reheat food for the residents because they noticed it was cold. During an interview on 03/10/2026 at 9:29 AM, Food Service Worker #46 stated they worked at the facility for eighteen years and started using the current meal delivery carts about three to five years ago. If a cart had a sign on it not to plug it in or turn it on it should not have been plugged in or even been in service. Hot food should be served at least 140 degrees Fahrenheit and cold food below 40 degrees Fahrenheit. Cottage cheese served at 68 degrees Fahrenheit was a concern. During an interview on 03/10/2026 at 9:55 AM, Food Service Director #40 stated the current delivery carts held one side cold and one side hot. When the carts were working correctly the temperatures were good, but they had two carts currently not working. The carts were always loaded correctly, with the hot food on the hot side and their most experienced staff checked the trays. A cart with a sign saying not to plug it in or turn it on should not have been plugged in. They stated the cold side would heat up if it was plugged in even if it was not turned on. If nursing left the cart doors open the temperatures would not be maintained. Hot food should be served at least 140 degrees Fahrenheit and cold food below 40 degrees Fahrenheit. Cottage cheese served at 68 degrees Fahrenheit, milk at 58 degrees (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fahrenheit, and egg and cheese croissants at 95 degrees Fahrenheit were concerns and not acceptable. 10 New York Codes, Rules, and Regulations 415.14(d)(1)(2)