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	05/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews (iQIES #3004417), the facility failed to ensure the resident environment remained as free of accident hazards as possible for one (1) of three (3) residents (Resident #1). Specifically, Resident #1 had a physician order for pudding thick liquids, was care planned to receive pudding thick liquids and was served thin liquids for dinner on 05/01/2026. Staff did not follow the facility process for checking meal trays against the meal ticket prior to serving and the certified nurse aide provided thin liquids instead of pudding thick liquids to the resident without verification. This resulted in no actual harm with potential for more than minimal harm past non-compliance for Resident #1. Findings include: The facility policy Meal Ticket and Dining Room Service, revised 03/2026 documented the licensed practical nurse was responsible for checking each tray prior to passing to the residents. The tray would be checked for accuracy including correct consistency, presence of all items stated on the meal ticket including adaptive devices, aspiration precautions, and allergies. The facility policy Feeding and Thickened Liquids Competency, revised 08/2024 documented food service provided pre thickened fluids (nectar and honey thickened) in the correct consistency on the meal tray. For fluids that did not come pre thickened, food service provided thickening packets, in the ordered consistency, for clinical staff to prepare before serving. Resident #1 had diagnoses including dementia and difficulty swallowing. There was no documented Minimum Data Set assessment in the record as the resident was newly admitted to the facility. The 04/30/2026 Registered Nurse Manager #3's admission Assessment documented the resident was alert to person only and they were on a pureed food, pudding thick liquid diet. The 04/30/2026 Hospital Discharge Summary documented the resident had a large, infected pressure ulcer that could not be surgically debrided (removal of dead tissue) as the resident was not stable to go to the operating room. The resident had a palliative consultation and started end of life care. The resident was to continue pureed and pudding thick liquids. The 04/30/2026 Comprehensive Care Plan documented the resident was care planned for end-of-life care and pureed/pudding thickened liquids. On 05/04/2026, the facility initiated an investigation after the resident's family member reported the resident had thin liquids on their dinner tray on 05/01/2026. The family member reported they notified Licensed Practical Nurse #2 on 05/01/2026 at the time. The family reported this to the facility on [DATE], following the resident's death. The 05/04/2026 Incident Report documented Certified Nurse Aide #1 gave the resident thin liquids through a straw without checking consistency with the nurse on duty. The meal tray was served without being checked by Licensed Practical Nurse #2 and Licensed Practical Nurse #2 did not notify the Supervisor of the break in the care plan. Staff statements obtained on 05/04/2026 documented: -Licensed Practical Nurse #2, they did not check the resident's tray prior to serving as they were passing out meal trays to other residents. Certified Nurse Aide #1 passed the resident their tray. The resident's family member informed them the resident had thin liquids on the tray, they did not notify a supervisor, and the resident was not assessed. They checked the resident through the overnight shift and noted no concerns. -Certified Nurse Aide #1, the resident's meal ticket did not identify the resident needed thickened liquids. Thin liquids were present (continued on next page)

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

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